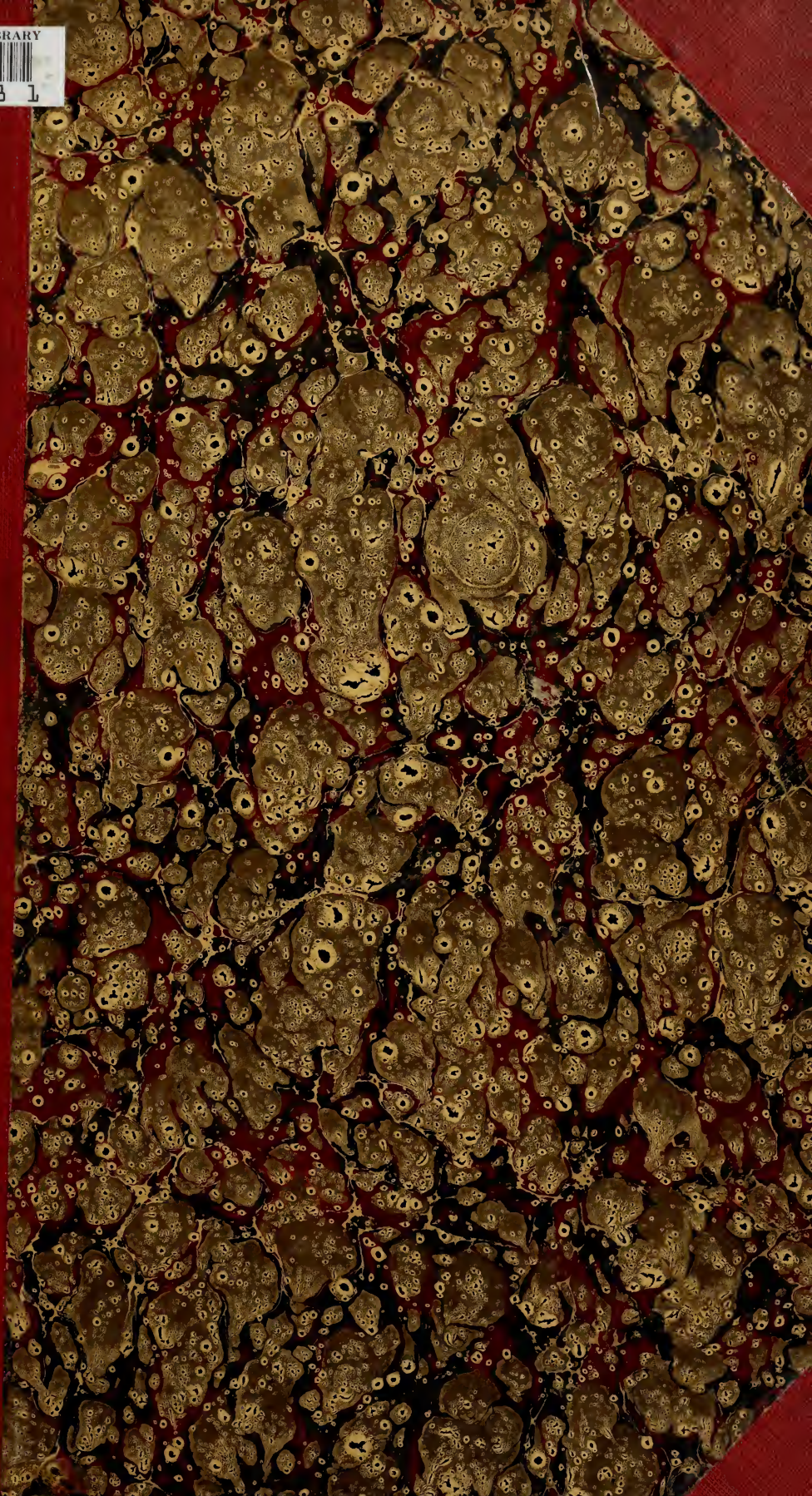


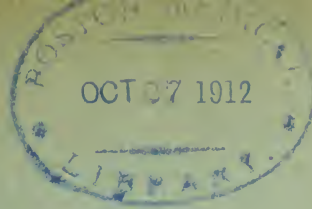
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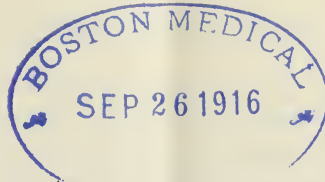
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VOL. III.

AUG., 1912.

No. I

THE PRESIDENT'S ADDRESS.

STANLEY P. WARREN, M. D.

I have the honor and pleasure of welcoming you to the sixty-first annual meeting of this association. Two generations of physicians have come and gone since that first meeting for organization at Lewiston, in 1851. Probably not a single member of that little company of founders is now living. At the session of the Association in 1878, when I was admitted to membership, there were a few of the charter members present and taking an active part in its business. I particularly remember among these the venerable Dr. Gilman of this city, a man of medium stature and quiet bearing, dignified in presence, and just finishing his long and honorable professional life. The home of the Association, as you know, was for many of its earlier years in this city, the sessions being held in the council chamber of the city building. This custom continued, with occasional pilgrimages to Bangor and Augusta, until the destruction of that building in the disastrous fire of 1908. After an interregnum of visiting our country cousins, we are once more assembling in the original home of the Association, and for the first time in this magnificent edifice. Erected upon the ashes of its predecessor, and stately in the simplicity of Colonial architecture, this center of civic life adorns our city and State, a fitting emblem of the development of our people in all the essentials of modern culture and good government.

In those earlier days of this organization, the founders builded well. With the prescience due to New England training, they planned, not only for themselves alone, but also for that ideal upon which the physician rests his claim for existence, the physical and moral welfare of the community. From the first enrollment of less than one hundred, we have increased to a present membership of more than seven times that number. Beyond the simpler aims of those earlier years, the scope of the Association has stretched out by successive steps of evolution, *pari passu* with those of medicine itself. Instead of being content with the narrower details of local and personal practice, our work has widened to include, with these, conservation of the rights of all of our people, which are, in the immortal words of the Declaration of Independence, "the right to life, liberty, and the pursuit of happiness." This association has initiated and fostered most, if not all, of those plans which are promoting the sanitation of the State; the organizing and maintenance of State and local Boards of Health, and the State laboratory. It has encouraged a popular sentiment in favor of public and private hospitals, of medical supervision of the public schools, and of the regulation of child labor. It is helping in the modern campaign of education regarding cancer, tuberculosis, venereal and other infectious diseases. Some of the more recent work of the organization, in its own behalf, is to result in a more vital connection with its component county societies for mutual growth and benefit. It has established an association journal for publication of the transactions and technical papers of this body and of our county societies, and also a State Medical Library. Most important of our later actions is the change in our organization which affiliates us not only with the national association, but also with the fraternity throughout the nation. By this act, we join with a united profession," to the end that it may receive that respect and support within its own ranks and from the community, to which its honorable history and great achievements entitle it."

With this brief retrospect of these sixty years, I think we have good reason to be thankful for the history of the association in the past, and humble before the magnitude of the problems for its service in the future.

Under our present form of government, the only gateway for entrance into this association is the county society. It is one of the units which, together with the other component county societies, makes up the Maine Medical Association, and, through combination with the other State Associations, the American Medical Association. "It is the only door to the State Medical Association and to the American Medical Association for physicians within its jurisdiction." (Con-

stitution of the Cumberland County Medical Society.) It is pertinent to the dignity and success of this, the supreme medical organization of this State, to consider whether our county societies are making good in this important office.

There are now established in our State, twelve county medical societies, which include about all of the territory available for the purpose. It has been my duty and privilege through the past year to represent this association at a large proportion of these, and I regret that lack of time has prevented me from visiting the entire number. From personal experience, I fully agree with the suggestion of my predecessor, made in the House of Delegates, that if this attendance, upon the meetings of the county societies, is to continue to be a part of the duty of your President, "it would be better to add the first Vice President and some other members to the force, and form the three into a visiting committee." It will be difficult and even impossible for your President, who is usually a busy practitioner, to satisfactorily do this work alone, because of the tax upon his time which such attendance requires. My visits have been received most cordially, and I have been impressed quite often with the high character of the papers and discussions. Anyone who thinks that our country practitioners are in the grammar-grade of medical study is most thoroughly mistaken. I hope that I shall not seem captious, however, when I say that the impression made upon me from these visits, with certain noticeable exceptions, is that our county societies are hardly living up to their opportunities. It seems to me that the customary attendance is not what it might be, and the general character of work is antiquated and rather common place. There are undoubtedly valid excuses for the stay-at-home. The long distances which must be travelled to reach some of the meetings; the necessities of daily practice which compel absence; possibly inclement weather, and other self-sufficient reasons. The actual attendance at the meetings, in proportion to the nominal membership, is noticeably small, so far as I have been able to learn. Not to multiply instances, at one society, at which I was present, only twelve members appeared out of a total enrollment of sixty; at another meeting, only seven out of forty members were counted. These numbers are in contrast with those in two other societies where, I am told, the proportionate attendance is seventy per cent. Nearly all the societies limit their program to one or more technical papers with a desultory discussion. Reporting of clinical cases, is either lacking, or is made and received in a style hardly worth their time. Such a program is not peculiar to this State, but is practically similar to that of the other States, and is arousing the wide spread study of thinking men into the causes of this

apathy and their betterment. Some of the plans recently suggested for making these meetings more attractive are the following: the holding of an open session once a year to which the general public is invited, and topics of mutual interest, scientific, legislative, public health, material and social affairs, are discussed. An attractive innovation is for two societies to combine in a neighborly visit to another society for better personal acquaintance as well as for professional work. A program of post-graduate study for the county society is supplied by the Journal of the American Medical Association, which is well worth trial. Although all societies include the reporting of cases in the order of exercises, this topic is so universally passed by with negatives, that it seems to have lost its deserved place on the program. A determined effort should be made to restore this very important detail of professional study to its rightful place as a helpful critique and counsellor. Most important of all, each county society should make particular effort to have every reputable physician, who practises in its territory, enrolled on its list of members. The county society, under our present organization, is the training-school of this association. The character of work in the former determines that in the latter, and no stream can rise higher than its source. It seems to me that the Association might appoint an Advisory Committee to help in this direction, who could offer through the Journal, topics suitable for the work of the county societies, that would induce larger attendance and greater personal interest in them.

At the last meeting of this body, a plan was presented in the House of Delegates for dividing the clinical work of the sessions among sections, but after discussion it was laid on the table. Last July, I sent a personal letter to the secretary of each and every State Medical Association, inquiring for any features in the programs of their annual meetings, which had seemed to make the occasion more attractive or raised it from the deadening level of the old-time debating society. Much to my surprise nothing of such a character was reported, the most useful recruiting agents for attendance being apparently social functions, ball games, excursions, and the like. Most State Associations continue the habitual plethora of papers by their own members, some reject entirely home papers and substitute for these addresses by distinguished outsiders. Two States, Massachusetts and New York, report increased attendance and interest since the adoption of the plan of dividing the literary work among sections. Notwithstanding the rejection of this plan at our last meeting, I am still of the opinion that it might be of benefit for us to try it. If the essayist was sure of the compliment of an audience and knew that he could have the criticism of a sharp, generous discussion by colleagues in that department or speciality, there would

evidently be a better prospect for a good paper than if it was fated to be read to empty seats in the general assembly. Everyone who has attended a meeting of the National Association will have remarked the crowded audiences in the sections, and the smaller number in the general assembly. With our increasing membership the number of appointments for papers could be greater, supposing that to be desirable, if one session, say that of each morning, could be divided between three sections: medicine, surgery and the specialities. Each of the members would probably find something personally attractive in one of these sections, instead of feeling obliged to listen to papers, read in the general assembly, upon topics unfamiliar or uninteresting to him. The afternoon sessions could then be given over to single papers on less technical subjects, either by members or invited speakers.

It is hardly proper for me to anticipate your discussion upon the propositions contained in the syllabus, sent to each member of the association with the March issue of the Journal. I refer particularly to the adoption by this organization of a Medical Defence Fund, the regulation of Medical Charities and the control of Contract and Lodge Practice. It is sufficient for me to say that I am heartily in favor of any concerted action, which will help to secure the professional and pecuniary rights of every person, young or old, high or low, who practises medicine, and that will take away the taint of commercialism which is lowering the quality and dignity of our profession in the estimation of the general public.

With our increasing membership and therefore increasing treasury, I suggest that this Association establish a scholarship in the Medical School of Maine, to be styled "The Maine Medical Association Scholarship," under the direction of the Dean and Faculty of the School. It shall be granted annually to any student in the senior year, who has shown special aptness for, or promise in his work, or by competitive examination, at the discretion of the faculty. It is to be used for post-graduate study at some one of the great centers of medical instruction. The exact amount of money settled upon the scholarship may be left to the vote of the association, but I suggest that at first it shall be one hundred dollars. This small amount may be increased after a time if the association finds that the purpose of the gift is being realized.

Surgery is a confession of defeat; the part diseased is beyond human repair, and the art of the surgeon is now concerned only with the quickest and safest method of its removal. Not so with medicine; its ultimatum is not the cure of existing disease, but rather the antic-

ipation of the need of the cure. Bernard Shaw says, "the true doctor is inspired with a hatred of ill health, and a divine impatience of any waste of vital forces." The whole trend of medical science in this twentieth century is for prevention rather than alleviation, and to that end it is toiling under the stimulus of increasing success.

Medical thought of the present is focussed upon the study of three diseases. Already the details of their treatment is generally established. But the future of the race lies in the solution of a far greater problem; the problem of their prevention. It is becoming more and more evident, that the only hope for attainment of that ideal rests upon popular education. A brief word concerning our special obligations to the public on these subjects lies within the scope of this address.

This association, as such, has not in the past interested itself particularly with the prevention of disease. As the acknowledged creators of medical thought and opinion in this State, an imperative obligation rests upon us in the warfare against the tubercle bacillus.

"Tuberculosis, which John Bunyan well termed the 'Captain of the Men of Death,' has from time immemorial up to our day and generation been claiming every third or fourth adult white life, and for several centuries past, every other negro adult life."

It behooves us, therefore, personally and as an association, to begin an active, forceful campaign of education in health conservation. To carry out this stupendous task, the plan adopted by the State of New York is suggested for your careful study, a plan accepted after large expenditure of money in testing the economy and efficiency of different methods. Let a demand be made upon the next Legislature for an enactment to enable each county, of sufficient size, to build and maintain a hospital, in which pulmonary tuberculosis, in all stages, may be treated for a nominal sum. Not only this, but it shall be primarily a place for the segregation and isolation of those with advanced disease, who, it is established, are the chief source of infection for others. With that end in view, it is essential that a crusade of instruction be commenced at once, and the medical profession be stirred to its responsibility in this economic and health problem. Once convinced ourselves of the importance of the problem, it follows that we press our convictions upon our patients and future legislators. A united profession would give this momentous subject a tremendous impetus.

In the history of cancer, it is safe to say that very few cases, if any, have been cured by medical treatment. No matter where the disease is located, it is to be conquered by surgery, and by surgery alone. Despite this fact, it is deplorable that many of this profession still persist in the medical treatment, so called, of malignant disease. Cases of suspicious character must be regarded as cancer until proven in-

nocent. Any physician who refuses to accept this rule, and particularly after a section for diagnosis has been obtained, is worse than negligent. The certainty of a fatal result, if the disease is left to its natural course, demands early and radical surgery. Education of the public in the danger of delay in establishing the true diagnosis, whenever there is a suspicion of malignancy, will create a healthy sentiment in favor of operative treatment. Careful explanation of the benefits of this method will encourage the timid. The general practitioner, who does not attempt capital surgery, should act in concert with those who believe in operation, and operation alone, for cancer. Acquaintance with the living pathology of malignant disease will induce them to advise and insist upon this method of treatment, before surgery is useless. The internist and the surgeon, the general practitioner and specialist, must sustain each other in this matter of common interest. Team work in cancer is as necessary as in all other conditions. Mayo says, ("Surgery, Gynecology and Obstetrics," Feb., 1912), "in all history of disease, there is no authenticated case in which a cancer of the stomach has been cured by medical means. Yet for some reasons which are apparent, and others which are not apparent, cancer of the stomach is treated by the physician, admitted to medical wards in hospitals, and only rarely is a surgical consultation considered necessary."

I believe the last word has been said regarding the best plan for conquering the so-called "venereal peril." The experience of the world with this greatest menace of all the ages is that legislation is ineffective in controlling the sexual desires of either men or women. Laws against the social evil exist in every government upon which the sun shines, but are avowedly for its regulation not for its arrest, and are to a large extent inoperative. Here in America the whole subject has been a *noli me tangere* until quite recently, or sporadically agitated by hysterical theorists. Two of our leading cities, New York and Chicago, have appointed Vice Commissions to investigate it. Their reports deal with the condition in its three aspects — moral, economic and medical. It has been clearly shown that the integrity of mankind "is distinctly affected by the increase in the diseases which are associated with prostitution, and therefore measures ought to be taken to insure a control of the venereal disease problem for the protection of the innocent and for the welfare of the children." The antidote for the disease is education in sex physiology, not only for adults but especially for the young people of both sexes. The part which the medical profession has to carry out in the administration of this teaching is to be settled, not in one generation but in succeeding generations. Of the plans for conducting this campaign of popular education, one of the

best is that of Dr. Bailey of Harvard. It is, to send out carefully worded letters of information to parents, with the request that the parents read them. If they find nothing objectionable in them to give these letters to their children, to read when they reach a suitable age. Our State Board of Health was unable to co-operate in this plan, on account of lack of funds, so that raising funds for beginning the campaign seems to be the first thing to be done. Letters containing a statement of facts have been sent to those who were thought to be interested in the plan, and already enough money has been raised to begin this work.

Gentlemen of the Association:—From an acquaintance with this organization of thirty-five years, I am confident that it has done good work. I am confident, also, that it can do better. For those of us who have grown grey in bearing the responsibilities of the sick-room and the amphitheater, the character of that work is well realized in the words of one of our wisest men:

"I regard it as one of the greatest blessings of living in this age and practising this profession, that we can do something with our hands, with our muscles, with our senses, for the service of the public."

For the consideration of our younger members, I submit the verse of Kipling:

"If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the will which says to them: 'Hold on;'
If you can talk with crowds and keep your virtue,
Or walk with Kings,—nor lose the common touch;
If neither foes nor loving friends can hurt you,
If all men count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the earth and everything that's in it,
And,—which is more,—you'll be a man, my son."

June 12, 1912.

THE APPETITE IN TUBERCULOSIS.

In view of the fact that hypernutrition, or so-called forced feeding constitutes one of the important indications in the treatment of many cases of tuberculosis, more than ordinary attention must always be devoted to maintaining the appetite. Unfortunately, many of these patients have an aversion to the very foods which are best adapted for repairing and resisting the ravages of the disease. It is here that Gray's Glycerine Tonic Comp. serves one of its most important purposes, by reason of its notable capacity to awaken a deficient appetite in a perfectly natural manner. It not only possesses the desirable feature of great palatability but through its tonic properties, it never fails to impart just the right tone to the digestive organs. Thus the effects are so much more permanent and far reaching than are obtained from ordinary stomachics, that not only are larger quantities of nourishment freely taken by the patient, but a correspondingly increased amount finds its way to the remote tissues.

A STUDY OF ECLAMPSIA AND TOXEMIA OF PREGNANCY.

R. W. WAKEFIELD, BAR HARBOR.

In the study of Eclampsia and Toxemia of Pregnancy the question that naturally arises at once is, are these diseases separate and distinct or are they different manifestations of the same disease? This question has been discussed a great deal in the past few years and I shall endeavor, in this paper, to present the latest conclusions.

DEFINITION.

Toxemia of Pregnancy is considered to be a pathological condition arising during the pregnant state in which certain toxins fail to be eliminated by the excretory organs but are stored up in the system causing characteristic symptoms, viz.: headache, visual disturbances, nausea, vomiting, delirium and coma with or without edema.

Eclampsia is considered to be a toxemia of the convulsive type, in which toxins, to us unknown, cause convulsions either before, during or after labor.

In analyzing the definitions it will at once be seen the only difference is that in one we have no convulsions and in the other we do.

ETIOLOGY.

The etiology of Toxemia of Pregnancy and Eclampsia is so little understood and even the theories are in such a chaotic state that I will not occupy your time in discussing them but will be content with a few general remarks on the subject.

According to McPherson, the uncertainty which we feel about Eclampsia begins with its very name. Webster's dictionary states that Eclampsia is derived from the Greek "eclapin," meaning to "shine out," and is defined as "a fancied perception of flashes of light, or convulsions."

Some observers even claim we can have Eclampsia without convulsions and then we are confronted with the paradoxical condition of "convulsions without convulsions." According to Harran, eclampsia is most prevalent during the spring months, reaching its highest point during April and then gradually diminishing until the least number of cases occur during November.

In hospital practice, toxemia of pregnancy and eclampsia occur in about 1.7 per cent of all labors, while in private practice, less than one per cent.

This difference in per centage can easily be accounted for by the fact that so many of these cases are sent to the hospital for treatment. The conditions occur almost twice as often in primiparae as in multiparae and are often seen in multiple pregnancies.

PATHOLOGY.

The pathology of Toxemia of Pregnancy and Eclampsia has been studied so thoroughly in recent years, I wish to discuss this phrase of the subject in some detail, because it seems to be in the pathology we have the best clue to the etiology and thus to the goal for which we are all striving, viz.: some rational and effective form of treatment.

It is certainly humiliating to think of the appalling mortality, both maternal and fetal; and the multiplicity of treatments recommended by physicians give testimony to the worthlessness of these methods of procedure, as the large majority has been directed toward abating the symptoms and not removing the cause. In this discussion of the pathology, I also wish to answer the question with which I began this paper, viz: whether Eclampsia and Toxemia of Pregnancy are separate and distinct diseases or whether they are different manifestations of the same disease. I shall discuss the Pathology of Eclampsia and Toxemia of Pregnancy separately, and then compare the two.

PATHOLOGY OF ECLAMPSIA.

The Pathology of Eclampsia is a subject which has interested the obstetrician since the beginning of his art. Before the days of post mortem research and urinary analysis the imagination of the practitioner formulated a pathology for this affection which was deduced from clinical symptoms.

In the process of reasoning backward from effect to cause, few persons will follow the same course; therefore, radically different judgments are formed. Thus we have many explanations of the causes producing the ensemble of symptoms which have so long been called eclampsia. The chief and one essential symptom of the condition is convulsions, with which certain others may be associated in a more or less pronounced form.

Until very recently, convulsions have been required before the diagnosis of Eclampsia should be pronounced. Even now it is an exceptionally bold diagnostician who will venture the diagnosis of Eclampsia without the presence of convulsions. Early in the era of post mortem studies of this condition, hope arose that the true explanation of the condition was at hand. Attention was largely centered on the nervous system as the seat of the affection, since the main symptoms seemed to point to that center. Changes in the brain

which were given to account for the convulsions were anemia, edema and apoplexy.

These observations were very good as far as they went but lacked comprehensiveness. In 1886, Jargens, by his careful labors, placed the pathology of eclampsia practically in the position which it now occupies. He was the first to describe the hemorrhagic liver changes now so well known and thoroughly identified with this condition.

In addition to the liver changes, he also gave an account of thrombi and liver cell emboli in the lung capillaries.

Encouraged by Jargens' work, Klebs, Pillut and others redescribed the hepatic hemorrhages and associated with them necrosis of liver cells and thrombosis of vessels. In addition they have shown us thrombi of other organs and emboli composed of liver and giant cells which they have described as being derived from the placenta.

The picture now accepted as typical of the pathology of eclampsia by the greater number of those familiar with the subject consists of hemorrhages in and about the portal spaces; thrombi in the vessels of the liver, and giant cell emboli in other organs. The changes found post mortem in the pregnant or postpartum woman are considered by many as a justification of the diagnosis of eclampsia regardless of the presence or absence of convulsions before death. And it is with these changes in mind that the clinician will occasionally make the diagnosis of "eclampsia without convulsions."

PATHOLOGY OF TOXEMIA OF PREGNANCY.

During the development of the pathology of eclampsia by the above mentioned investigators, it was discovered that many pregnant and postpartum women, dying from a systematic poison, diagnosed toxemia of pregnancy, showed different lesions from the ones described above in connection with eclampsia. Instead of hemorrhages about the portal spaces associated with thrombi and emboli, extensive necrosis was found associated with advanced degenerative processes which when formed early were limited to the central part of the liver lobule, but later invaded the remaining part of the lobule and produced a picture typical of acute yellow atrophy of the liver.

Therefore, two sets of views have developed in regard to the two conditions. One is that eclampsia and toxemia of pregnancy are entirely different diseases; eclampsia having hemorrhages about the portal spaces as its characteristic lesion while toxemia of pregnancy was characterized by central necrosis of the liver lobule.

The following cases were examined post mortem by Welch in the New York Lying-in Hospital:

CASE I.

Diagnosis, Eclampsia.

Patient, aged 21, primipara.

History: this patient had never been ill. Had no morning sickness. Five weeks before confinement, had slight morning headache and swelling of legs. These symptoms were better three weeks before confinement. Trace of albumen in urine. At full term, gave birth to twins, at 7.30 P. M. At 11 P. M., was seized with convulsions and died eight hours later in coma.

Autopsy: Brain, all ventricles filled with blood.

Liver: color light yellow. Extensive hemorrhages under capsule and through liver substance.

Microscopically, numerous hemorrhages about portal spaces and *liver cells show cloudy swelling, fatty degeneration and beginning necrosis.*

CASE II.

Diagnosis; Eclampsia.

Patient: aged 28 years iii para.

Eighth month of gestation.

History: She had had two previous normal pregnancies and labors. During last previous pregnancy, she had slight edema of the ankles. She enjoyed good health up to time of attack, which came suddenly at 11 A. M., as a very severe headache. She felt fairly well during the afternoon. At 11 P. M., she had a general convulsion. She was brought to the hospital two hours later in coma, in which she died four hours after admission.

Autopsy: Brain, all ventricles filled with blood.

Liver: Extensive hemorrhages beneath the capsule and through the organ.

Microscopical, extensive hemorrhages found in and around the portal spaces. Liver cells show cloudy swelling, fatty degeneration and pigmentation. Kidneys show subcapsular hemorrhages and degeneration and sloughing of the epithelium lining the tubulis.

CASE III.

Diagnosis: Toxemia of pregnancy.

Patient: Aged 30, iii para.

Ninth month of gestation.

History: Patient was brought to the hospital in an ambulance, having suffered from dizziness, headaches, swelling and pain in the legs for three weeks. After rest in bed and a limited diet, the subjective symptoms disappeared, but the swelling of the legs persisted.

She had a nervous labor at 9 A. M. At 1 P. M., without having convulsions, she went into coma, which gradually deepened until 5.30 P. M., when she died.

Autopsy: brain, ventricles filled with fluid and clotted blood.

Liver: Extensive hemorrhage beneath the capsule and through the organ.

Microscopically large hemorrhages found in and about the portal spaces. Liver cells about hemorrhages show degeneration and necrosis, also large accumulations of leucocytes.

Kidneys: extensive degeneration and sloughing of epithelial cells lining the tubules of the cortex.

CASE IV.

Diagnosis: Toxemia of Pregnancy.

Patient: aged 30 years, iv para.

Seven months pregnant. She was comatose when admitted; pupils were contracted; patient was generally cyanosed; there were no convulsions. Anterior lip of cervix incised and child delivered by interval podalic version. Patient died on day of operation.

Autopsy: brain, convulsions flattened. Ventricles filled with blood. Hemorrhage in pons.

Liver: Extensive hemorrhage beneath the capsule and through the organ.

Microscopically, liver cells show cloudy swelling and fatty degeneration. Extensive hemorrhages in and about portal spaces.

Kidneys: organs much increased in size.

Cortices swollen and parenchyma shows albuminous degeneration and extensive sloughing. Thus it is seen that since careful microscopical examinations of the liver substance have been made, we find both hemorrhages and cell necrosis in the same subject and the clinical diagnosis may have been either Eclampsia or Toxemia of Pregnancy. In other words the same pathological condition is often found in both diseases; therefore the arbitrary statement that Eclampsia is characterized by hemorrhages in and about the liver lobule and toxemia of pregnancy by necrosis of the liver cells we now know is incorrect.

In conclusion I will state that the latest thought in regard to Eclampsia and toxemia of pregnancy is that they are of the same morbid process and simply represent different manifestations of the same disease.

On account of the extensive cell destruction found principally in the liver and kidney, these diseases are supposed to be caused by some enzyme.

TREATMENT OF PUERPERAL ECLAMPSIA.

The best theory of the present day as to the etiology of Eclampsia, although it may not be correct in all details, is that it is due to toxemia. If this is true, then the prophylactic treatment of eclampsia is far more important than the curative. Hence the necessity of regular and frequent examinations of the urine and the immediate institution of appropriate treatment and diet as soon as any abnormality is detected or symptoms appear which would indicate that the eliminative processes are at fault. It is true that renal complications may exist during pregnancy without the supervention of any special symptoms. Such, however, is the exception, for in addition to the physical signs of kidney inadequency such as a diminished amount of urine passed and the presence of more or less albumen in the urine, with a gradual diminution in the amount of urea secreted, we should also watch for the general symptoms of a circulation overcharged with poisonous materials such as high arterial tension, headache, dizziness, gastric disorders, mental and physical lassitude and disturbances of the bowels, liver, skin and lungs, with more or less oedema of the feet, extremities, face and genitals, spots before the eyes, at times, transient inability to see at all, dyspnoea, etc.

Given a patient presenting such symptoms as I have just enumerated, I would suggest the following treatment: (1) the amount of nitrogenous food should be reduced to a minimum and this can best be met by an exclusive milk diet, to which, as the symptoms improve, fish and white meats may be added; (2) the production and absorption of poisonous materials in the intestines and body tissues, should be limited and their elimination aided by improving the action of the skin, the bowels, the kidneys, the liver and the lungs; (3) In order to get rid of the fetal metabolic products, and the periplural irritation in the uterus, that organ must be evacuated. To meet the second indication, namely elimination, the patient should have abundance of pure air and water, with gentle exercise and massage. The bowels should be kept free by the administration of laxatives, especially salines. The patient must be protected from the possibility of taking cold, so to speak. She should wear flannel next the skin, which will also tend to keep the skin moist, such diaphoresis assisting and relieving the kidneys. The sweat glands also eliminate the carbonate of ammonia, into which the urea is changed. Frequent warm baths are valuable in inciting the sudoriferous glands to action. If necessary, the hot pack should be resorted to, associated with high rectal irrigation of water at a temperature of 118 degrees F., also instances where there

is high tension of the pulse. Nitroglycerine should be ordered in full doses, 1/50 gr. should be given every three hours until the tension abates and then at greater intervals as indications call for.

By attention to these measures it may frequently be possible to carry the woman to term without the supervision of eclampsia. At present, however, despite all we can do, cases of eclampsia will still occur, and sometimes in patients who apparently have responded satisfactorily to prophylactic treatment. Experience proves that cases accompanied by œdema are more readily amenable to treatment and less likely to eventuate in eclampsia than those in which it is absent. In instances where, notwithstanding these dietetic and hygienic measures, the albumen increases in amount or the urea diminishes, and the other symptoms, headache, œdema, etc., become intensified instead of lessening, then in the words of Graves in the time for dallying has ceased, and it becomes the duty of the physician after due consultation, to take steps for the emptying of the uterus.

When eclampsia develops suddenly, with or without the premonitory history, we have dwelt upon these time is not to be lost, for as Lusk aptly puts it, the time for folded arms has gone by. The uterus must be emptied by as rapid a measure as is consistent with the integrity of the woman's genital tract, she cannot hope by delay to save the child, and each recurring convulsion simply makes matters worse for the woman. I recognize the fact that some of you present today, may challenge the method of treatment I am now advocating as altogether too radical and you may agree with Gooch who says, "Attend to the convulsions alone, and leave the labor to take care of itself," or with Chroeder, who says, "Especially no kind of obstetric manipulation is required for the safety of the mother," but he is forced, however, to admit that it is sometimes advisable to hasten labor to ensure the safety of the child.

It seems to me that the question as to the advisability of early operative interference can only be fairly decided by determining the proportion of cases in which the convulsions cease after the birth of the child. Statistics bearing upon this point have been carefully adduced by Dührssen, Olshausen and Zweifel, who noted a cessation of the seizures in 93.75 and 85% respectively. Zweifel reports a mortality of 29% under expectant treatment and only 11% under active interference. Judging from these statistics, it would appear that prompt delivery is indicated especially when convulsions are actually present, furthermore Green of Boston has shown that the maternal mortality, when convulsions occur before labor sets in is forty-six per cent; fetal mortality, sixty-nine per cent; when labor is induced, the maternal and infant mortality is each twenty-five per cent; in postpartum eclampsia, mortality of mother is only seven per cent.

Moreover in the vast majority of instances, the development of eclampsia leads to premature labor. If we do not then, as Jarman says, shut our eyes to nature's teachings, it certainly seems wise to resort to such measures as will hasten the emptying of the uterus, instead of to such as will tend to protract gestation. The latter cause will certainly avail naught to the child, for its life is directly imperiled by the first eclamptic attack and should it survive this and labor not occur spontaneously, its chances of living through further attacks are very much lessened, for besides the danger to the child from the pressure resulting from the maternal convulsions, it is liable to asphyxia, caused by compression or oedema of the placenta, or from an extreme amount of carbon dioxide in the blood, or it may be by direct poisoning by the toxins in the maternal circulation. Moreover, the vitality of a child, born of an eclamptic mother is always below normal, and it often dies in the first twenty-four hours. As regards the woman, if spontaneous premature labor do not occur, during the first attack, experience teaches that the liability to further attacks is far greater if the uterus has not been emptied than where it has. The first exhausts the woman, if it do no more; the second attack adds to the exhaustion, the risk of cerebral apoplexy, asphyxia, caused by spasm of the glottis and respiratory muscles, oedema of the lungs or brain, following serous effusion from over charged capillaries. Congestion of the brain as evidenced by coma or cardiac paralysis with instant death.

In view of these facts in general, nothing is gained by trying to protract gestation and all may be lost. Of course, in cases in which the convulsions come are during labor, with strong and effective pains, no interference is necessary. It is possible, too, that in a well-regulated hospital, there may be some excuse for delaying the operation of accouchement force, where convulsions come or before the child is visible and where skilled attendants are constantly present, ready at any time to interfere if further convulsions develop, but I am writing now about treatment of cases that we as general practitioners encounter outside of hospitals and often beyond the reach of so much as a trained nurse. Whilst awaiting the action of the method selected for emptying the uterus much may be accomplished by resorting to measures tending to lessen arterial tension. Where the pulse is full and bounding venesection may be resorted to. As much as ten to sixteen ounces may be withdrawn, according to its effect upon the pulse.

Personally, however, unless the patient is particularly robust, I would not bleed, as if you have to empty the uterus by accouchement force or otherwise, the patient would probably lose sufficient blood to reduce the pulse tension, without the need of venesection, especially if we resort to nitroglycerine or *Veratrum Viride* hypodermically. The former may be used in one-fiftieth gr. doses and repeated hourly for a few doses if required. Inhalations of chloroform to the extent of

surgical narcosis from the most reliable of all methods for the control of the eclamptic seizure.

Edgar says that *Veratrum Viride* inefficiency, stands second only to chloroform. With the pulse strong as well as rapid, it offers the most certain means at our command for temporarily and even permanently controlling the spasms. With a weak pulse, however, morphine hypodermically, inhalations of chloroform and chloral and sod. 40 gr. of each by per rectum may be used instead. In using *Veratrum Viride*, the pulse rate is soon diminished and convulsions are almost unknown, when the pulse rate is reduced to C. O. the temperature is also reduced and the rigidity of the cervical rings relaxed; diaphoresis and diuresis are promptly effected, thus aiding in the elimination of the unknown toxins. Edgar's initial dose subcutaneously is ten to twenty minims repeated in ten minim doses every one-half hour till the pulse remains below sixty. The patient must be kept recumbent whilst under this drug. If vomiting or collapse threaten, morphine or whiskey will readily control both. Of course the eliminative organs must be stimulated to the utmost. Croton oil upon the tongue or calomel or jalap powd. by the mouth if able to swallow, may be used at once, followed by salines and high enemas. Dry or wet cups over the kidneys, followed by hot, moist applications is an excellent way of stimulating diuresis. The hot air bath or the hot pack encourages diaphoresis. Pilocarpin, owing to the tendency to pulmonary and of this oedema, is generally contraindicated. Collapse, attended by a small compressible pulse is an indication for saline infusions, or subcutaneous or rectal injections.

Careful observations seem to show, however, that in about ninety per cent of the cases, the danger is essentially passed immediately after the uterus is emptied. The convulsions do not always cease by this method, but they become less dangerous and the case is converted into one of postpartum eclampsia in which as has already been stated, the mortality is only about seven per cent; whilst on the other hand, expectant or palliative treatment only will almost surely be followed by death of the child, and about one-third of the mothers succumb.

Of the various methods of emptying the uterus, I would mention (1) Cæsarean section, with its mortality of thirty-six and one-fourth per cent; (2) various methods of mechanically dilating the cervix; (3) deep incisions, which at once completely remove the barrier of the cervix; (4) combined mechanical dilation and deep cervical incisions. I would recommend manual or mechanical dilation of the cervix and prompt extraction of the foetus. If it is impossible to insert more than one finger into the cervix, I would use steel branched dilators till I could insert another finger, after which further dilation can be accomplished without the use of any instruments or dilating rubber bags of any kind. If after dilation, the head is engaged and moderately low in the pelvis, I would use forceps, or if only slightly engaged or movable above the pulvic brim, would resort to version.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

The President, Dr. Marsh.

The Association in choosing Dr. Ralph H. Marsh of Guilford for President, has made a wise choice. Dr. Marsh was born in Greenville. He graduated from the University of Maine in the class of 1888 and received his medical education at the Medical School of Maine, receiving his diploma in 1894. For one year he practiced in Lincoln and then settled in Guilford; where he has worked ever since.

In town affairs, Dr. Marsh has always been willing to do his part, having been Town Treasurer at one time and served on the School Committee for twelve years. He has been United States Pension Examiner since 1900. He was the prime mover in organizing the Piscataquis County Medical Society; was the second President of the society for two years and has been Secretary of the Society for a number of years. Dr. Marsh has done more than any other member to keep the Society in an active condition.

He has been a member of the Maine Medical Association for a number of years and has served as Counselor of the sixth district for the three past years. He punctually attended to his duties as Counselor, visited the meetings of the different County Societies in his district and endeavored to cultivate a close relationship between the State Association and the County Societies. He has been a regular attendant at the annual meetings of the Maine Medical Association and his election to the Presidency is a fitting acknowledgement of his work

for and interest in the welfare of the Association and demonstrates that the Association stands ready to honor those who merit the honor, by service in its behalf.

Dr. Marsh is a cautious, conscientious physician, quiet and unassuming. He is held in the highest esteem by his colleagues and his standing in the community in which he lives and works is secure.

American Medical Association Meeting.

The Annual Session of 1912 presented the usual complete and effective program of the various sections. During the four days' session, some fourteen sections were meeting daily for the presentation and discussion of all things new in their particular lines during the past year.

At the opening of the general session, a brief address of welcome by the Mayor of Atlantic City and the words of welcome by Governor Woodrow Wilson, in behalf of the State of New Jersey, were most pleasantly received, while President-elect Dr. Jacobi's address will long be remembered. The various sessions were well attended, while the subjects offered, although not all new, showed a very careful review of the matters under consideration.

It is a regrettable fact that so few Maine physicians take advantage of the opportunity to attend these meetings when held in the East. Not only are matters pertaining strictly to medicine being considered at these sessions, but all matters pertaining to Public Health, Medical Legislation, Medical Education, etc., are considered. It should be borne in mind that the great business body of the American Medical Association is composed of the House of Delegates, which in turn, is composed of the Delegates elected by the various State Associations, so that Maine should take an active interest to see that her Delegate is instructed as to her attitude, as to questions of interest and in order to have that Delegate's services of any value, he should be elected for a term of office sufficiently long for him to become conversant with the way business is done by those large bodies, and, moreover, the State Association should bear the burden of expense rather than the Delegate who is elected to serve. It is a simple matter to criticise the working of the National Body, but it is equally simple for Maine to be amply represented in the National Body, and by some member whose interests in this work will call him to attend each Annual Session and become thoroughly conversant with the methods of procedure. We cannot speak too highly of Dr. Bennett's enthusiastic work of this year, and sincerely hope that the Council will reimburse him for his expenses to the National Meeting.

This year, he will be in a position where he can act more readily and do considerable work as it takes at least one session for a Delegate to get on to the ropes, so to speak. In a few years, Maine will send two Delegates and it is always a simple matter to arrange enough State Delegates on the right side of the question, providing they are familiar enough with the work, to block any objectionable features that come up in the National House of Delegates.

New Life in County Societies.

A few County Societies hold meetings in September and are arranging their programmes for this year's session. The past year has shown a noticeable increase in membership, while the younger members are taking hold of the work in earnest.

The majority of counties are carrying on a campaign to secure every eligible physician to membership. The Journal has gladly co-operated in this work and stands ready to assist in every way possible. During the year, many papers are sent in for publication from the various counties. These are placed on file and in some instances, the authors have signified a willingness to read their paper before other bodies if desired, while none of them have refused to respond to an invitation. A list of these papers will be sent to any County Secretary on request, also an abstract of any paper selected from this list. In this manner, the Journal can and will gladly co-operate with the County Societies.

We are very desirous of obtaining more complete reports of the meetings including the number and names of members and guests present; case reports; discussion of papers, etc. A complete report as outlined will be of utmost value. The discussion of papers will be published with them or, where it is not possible to secure copies, send in abstracts with discussions. If the County Societies will appoint a member, as County Editor, who has demonstrated an active interest in his Society's work and preferably, one who has had some experience along these lines, it will insure active representation. The above field of work is the most useful one for the County Societies and represents one of the strongest arguments in favor of starting a State journal. It now remains with the Societies to take the initiative.

The Meeting of the Association of State Editors and State Secretaries.

On the evening before the general session, there was a meeting of the Association of State Editors and State Secretaries at the Marlborough-Blenheim. Dr. McDavitt of St. Paul read a paper on "Uniform Regulation of Membership," Dr. Taylor of Texas read a paper on "Transfer from the County Societies of one State to Another

without Cost." Dr. A. T. McCormick read a paper on "Malpractice," after which a full discussion of the above questions was entered into. During the latter part of the evening, President J. B. Murphy, Ex-Presidents, C. A. L. Reed and W. H. Welch; Dr. Alex. R. Craig, Secretary of the Association, and Dr. G. H. Simmons, spoke briefly on matters pertaining to the general organization work.

The following officers were elected for the ensuing year: Dr. H. Taylor, (Editor Texas State Journal) President; Dr. D. S. Fairchild, (Editor Iowa State Journal) 1st Vice-President; Dr. Perry Bromberg, (Editor Tennessee State Journal) 2nd Vice-President; Dr. L. H. Smith, (Bowling Green), Secretary.

Another meeting will be held, in Chicago, some time in the Fall to take under consideration the various problems submitted and to endeavor to reach a satisfactory solution of them.

Dr. Vaughan's Sanitarium.

A small Hospital and Sanitarium for the treatment of medical, neuropathic and pscopathic cases was opened at Yarmouth for the reception of patients July 1st.

It is a quiet, retired place surrounded by a luxurious growth of foliage. There are about four acres of land about the main buildings, which is invisible from the village street. The lawns, trees and shrubs are in a fine state of cultivation and give evidence of expert care and the lavish expenditure of money.

There are inviting shady paths in the rear leading to the river (Royal) and bay which, at this season, is dotted with pleasure boats of all varieties. Of great value among the natural advantages of the retreat is the fine spring, said to be unsurpassed by any of the much lauded bottled waters on the market.

By rational and conservative methods of treatment and by proper observance of professional ethics the management expect to and undoubtedly will command the endorsement of the medical profession.

The transportation facilities are exceptionally good. The Grand Trunk Railroad station is opposite the entrance and frequent trains make the run to Portland in twenty minutes. The electric road runs cars every one-half hour to Portland as well as to Brunswick, Lewiston and Augusta.

SURGICAL SUGGESTIONS.

If suppuration at the root of the nail does not soon subside after providing drainage, it may be necessary to remove the nail. This should not be done too hastily, however. Persistence in daily disinfection of the space (iodine, hydrogen peroxide, etc.) and stimulation of the tissues (as by massage) will often be rewarded by saving the nail.—*American Journal of Surgery.*

Necrology.

SAMUEL BEECHER HUNTER.

Dr. Hunter was born in Strong, Maine, July 18, 1830, and died in Machias, Maine, June 2, 1912, as the result of a fractured hip three years before, complicated with the burdens of advancing years. He attended school in the town of his birth, followed through the curriculum of Wilton Academy, and then began the study of medicine, obtaining his degree at the Jefferson Medical College in Philadelphia, in 1852, being then twenty-two years of age. Looking about for a suitable place for permanent practice, he tried first at Strong, then in Steuben, next in East Machias, and finally he settled for life in Machias and practiced there for fifty years. His field of practice embraced all of Washington County, over which he drove day and night for years, doing good work in medicine, obstetrics and surgery of the minor sort.

He went early into the Civil War and was surgeon during most of those warlike days to the 7th Maine Regiment, and came home as full surgeon with the rank of Major. From the experience thus obtained he built a broad foundation for his extensive medical practice. He had charge of the Marine Hospital in Machias for years, and was long a pension examiner for the district in which he lived. His decisions were highly considered in difficult cases of army disability.

Dr. Hunter was a very active member of this Association, read before it a clever paper "On Uterine Fibromata with Complications," at a time when such cases were rarities, and as President of the Association in 1889 conducted its deliberations with gentle skill and delivered a most instructive presidential address. Tall and commanding in presence, with a gentle voice, yet firm manner, Dr. Hunter was a valuable member of the Association and one around whose name many pleasant memories of his abundant kindness and hospitality hover.

Dr. Hunter belonged to the American Medical Association and to many local societies. He was a deeply religious man, and most courteous and polite to others. His declining years were saddened by the loss of his devoted wife. He is mourned by two daughters, one of whom, Dr. Sarah Hunter, has followed in her father's footsteps as a practitioner of medicine and member of our Association. It is with a sense of a personal loss that I recall many courteous consultations with Dr. Hunter in my early professional life in Maine. J. A. S.

Abstracts of Current Literature.

UNDER THE CHARGE OF THE MEDICAL REVIEW CLUB
OF PORTLAND.

(Annals of Surgery, January, 1912.)

Fracture of the Floor of the Acetabulum.

By Penn G. Skillern, M. D., and Henry K. Pancoast, M. D.,
Philadelphia.

The writers commenced the article with a report of four cases seen by them. In the first case, nothing was revealed by external measurements, as they were all correct. It was only by rectal examination and by means of a skiagram that the diagnosis was made. In all four cases, skiagrams showed that the head of the femur was displaced into the pelvic cavity. The treatment for the several cases was not given and they were all old ones, ranging from two and one-half to eleven years since the fracture. These cases are comparatively rare; there being, since 1788, only fifty-five cases reported. The causes are almost always falls from a considerable height, like twenty feet, in which the patient strikes upon the ground, hitting the greater trochanter. Blows from heavily swinging objects, striking the greater trochanter may also cause fracture. The acetabulum being very thin at its deepest part does not, of course, have much strength, so that if the bony material in the neck of the femur is stronger than that of the acetabulum a fracture with perforation may take place. In addition to the pain on motion, disability, and tenderness, diagnosis is made principally upon the following two signs:

The detection of the head in the pelvis by rectal examination and the approximation of the trochanter to the symphysis. Under complications there may be, in addition to the external bruises, haematomata, injuries to the pelvic blood vessels, the obturator nerve, intestine or bladder, and these things should be kept in mind during the process of examination.

In the absence of complications, the prognosis seems good.

In the way of treatment, the authors lay special stress upon the fact that the pelvic organs should be examined for injury the first thing before anything is done for the fracture. After that, the head should be reduced in the acetabulum, both longitudinal and lateral traction maintained for a few days, and then plaster of Paris applied

from the toes to the lower borders of the ribs. After union is assured, massage and passive motions should be employed to increase function.

H. A. PINGREE.

February 2, 1912.

(Annals of Surgery, January, 1912.)

The Surgical Treatment of Colitis.

By Charles Langdon Gibson, M. D., New York.

The author's article covers those cases of colitis where irrigation can be used to advantage. He speaks of the first operation in which an artificial anus was made use of. This necessitated the wearing of a dressing all the time, and its repair required a rather severe surgical operation with high mortality.

The method of the author is the insertion of a tube into the head of the colon through which the washing may be done. This does not prevent the fecal current from passing through the colon and does not necessitate the wearing of a dressing, both of which are required by the artificial anus.

Through a McBurney incision, the head of the colon is exposed and a tube passed through its wall into its lumen. By the arrangement of two layers of Lembert sutures, a valve is formed by the infolding of the wall of the gut so that when the tube is withdrawn, the hole occupied by it closes up, and even under the pressure of distension no fecal matter will escape. The upper layer of sutures also fastens the colon in the wound. If at any time the washing ceases to be necessary, by leaving the tube out for a day the wound in the gut will be healed. It is only by the insertion of the tube for two or three times a day for washing purposes that the wound is kept open. He considers this much better than the appendicostomy, inasmuch as the appendix is often located in an unfavorable position and oftentimes its lumen is not sufficiently large.

The normal salt solution is the principal fluid used for mechanical washing purposes, and he thinks that ordinary ulcerative cases may be cured by this method, but that amoebic or tuberculous colitis cannot be relieved.

H. A. PINGREE.

February 2, 1912.

(Medical Record, Dec. 23, 1911. Vol. 80, No. 26.)

Putrefaction Toxemia.

By Edward E. Cornwall, M. D.

The author of this paper reports twelve cases in which the following conditions were present. Severe and frequent headaches, mental and physical debility, functional disorders of the heart, irritative cough, glycosuria, eczema, toxemia of pregnancy, cardio-vascular disease and nephritis. Normally putrefaction products are formed in the intestinal tract as a result of the action on animal protein of the ever present saprophytic bacteria, but it is only when the toxins thus formed become excessive or some abnormal conditions exist, that pathological conditions are produced.

The conditions which favor intestinal toxemia are excess of protein, the character and activity of the bacteria, the alkalinity of the intestinal contents, stasis, the condition of the intestinal mucosa, the functional activity of the liver and ductless glands, the activity of the eliminative organs and the amount of tissue resistance of the individual.

The diagnosis of putrefaction toxemia can usually be made by the therapeutic method. This method consists in giving an antiputrefactive diet and watching results. If great improvement follows the diagnosis is confirmed. The writer considers this method much easier and on the whole more satisfactory than any of the laboratory methods at our command.

The treatment of this condition is mainly dietetic, and consists in reducing the putrefiable protein ingested, increasing the amount of lactic acid formed in the lower part of the intestinal tract, eliminating cane sugar and other disturbing articles of food from the diet, laxative when needed. Milk, butter, cheese, olive oil, bacon, bread, cereals, vegetables, fruits and honey are the articles of food usually given. Also reduce the total quantity of food to the smallest amount necessary to maintain nutrition in any given case.

A. H. WEEKS.

FOR SALE.

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CUMBERLAND.

THE PORTLAND MEDICAL CLUB.

The annual outing of the Portland Medical Club was held at Mitchell's, July 9th. The Committee was composed of Drs. E. E. Holt, Jr., J. B. Drummond and M. C. Webber.

Most of the afternoon was given over to a ball game followed by a shore dinner. They returned early in the evening by automobile. There were about forty members present.

H. J. EVERETT, *Secretary*.

HANCOCK.

HANCOCK COUNTY MEDICAL SOCIETY.

The regular meeting of the Hancock County Medical Society was held on Wednesday, July 17th at Bar Harbor.

Owing to the absence of Dr. Higgins, the president, the meeting was called to order by the vice-president, Dr. Ober.

1. Reading of minutes of last regular meeting.

2. Business.

3. Paper: Backache. Some suggestions as to cause and treatment, by Dr. Ober, Northeast Harbor, Maine. Discussion opened by Dr. Augustus Thorndike of Boston.

4. Paper: The Prevention of Insanity, by Dr. Frederick L. Hills, Superintendent of the Eastern Maine Insane Hospital, Bangor, Maine.

Discussion opened by Dr. George A. Phillips of Bar Harbor, Me.

The paper read by Dr. Hills was extremely interesting to all and was well discussed.

We were royally entertained by Dr. George Hagerthy, at his home, a delightful buffet lunch being served at the close of the literary exercises when we adjourned.

By FRANK R. OBER, *County Editor*.

PISCATAQUIS.

The Piscataquis County Medical Society held its regular meeting at Milo, Thursday, July 18th. Banquet at Milo House. Ladies invited.

Dr. F. H. Jackson of Houlton read a very interesting paper on "Cancer of the Uterus." Large attendance and a very profitable meeting.

WASHINGTON.

The next regular meeting of the Washington County Medical Society will be held in Machias, August 8th.

H. B. MASON, *Secretary*.

YORK.

The 69th quarterly meeting of the York County Medical Society was held at the Ocean View House, Biddeford Pool, Thursday, July 11. Shore dinner was served from 1 to 2 o'clock. A short business session followed the dinner.

In the absence of the President and Vice-President, Dr. J. M. O'Connor, Biddeford, was chosen as chairman of the meeting. The minutes of the April meeting were read and approved.

Bills were presented for approval and it was voted to pay the same. The application of Dr. Frederick C. Lord, of Kennebunk, and Dr. Ivan Staples, of Limington, having been approved by the Board of Censors, they were elected to membership in this Society. There was a brief discussion in regard to increasing attendance at our meeting and enlarging our membership.

This meeting was the annual mid-summer outing and ladies' day of the Society and it was a pleasant occasion for all present.

The next session will be held in October.

Members present: Drs. Ferguson, O'Connor, Maynard, Precourt, Traynor, Biddeford; Cochrane, Powell, Saco; Prescott, Kennebunkport; Wentworth, Sanford; Jones, Old Orchard. Guests: Drs. Gilbert, Portland; L'Heureux, Sanford; Bergland, Biddeford Pool.

Twenty-one were served at dinner.

ARTHUR L. JONES, *County Editor.*

Correspondence.

Portland, June 22, 1912.

Editor, Journal of the Maine Medical Association:

Dear Sir:—In the paper read June 13, by P. W. Davis, there are two statements which might possibly cause misapprehension. As to these two matters, the facts are as follows:

First—The Medical School of Maine is an integral part of the corporation of Bowdoin College.

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rhoids and pruritus ani.

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PERSONAL NEWS AND NOTES.

Dr. Frank R. Ober, Northeast Harbor, was appointed County Editor for Hancock County.

Dr. Adam P. Leighton, Jr. of Portland, has returned from a year's stay abroad.

Dr. E. D. O'Neill of Biddeford has opened a summer office at Old Orchard.

Dr. L. A. Girard of Biddeford returned July 17th from Montreal, where he was called by the illness and death of his father, A. P. Girard, the burial taking place, Tuesday, July 16th, at Montreal.

Dr. C. E. Kendall of Biddeford attended a school for the medical officials of the State of Maine National Guard which was held at Norway three days the week of July 7th. There were three sessions each day at their headquarters at Dr. Bradbury's hall on Water Street. Friday night the militia boys marched to Dr. Parker's farm between Norway and Oxford and camped there on the field until Saturday afternoon. The doctors practised dressing and bandaging the wounds of the afflicted ones. The guard is liable to be called into service at any time and at the Fall maneuvers they will be called into service.

The personnel is as follows: Colonel E. M. Fuller, Bath; Major B. F. Bradbury, Norway; Major Clarence E. Kendall, Biddeford; Captain J. C. Towne, Waterville; Lieutenant H. H. Sampson, Soldiers' Home, Togus; Lieutenant W. L. Haskell, Lewiston; Lieutenant D. M. Stewart, South Paris; Lieutenant H. R. Farris, Oxford; Lieutenant E. E. Goodrich, Waterville.

Dr. John H. Neal, now of Portsmouth, N. H., and formerly of Sanford, is mentioned as a possible successor to President W. D. Gibbs of the New Hampshire State College at Durham, N. H.

Dr. F. F. Bernier of Sanford has returned from Rumford Falls, where he conducted the initiation of a class of twenty-five candidates in the society of St. John de Baptiste.

Dr. Katherine L. Storm, who several years ago patented the Storm Binder, has recently obtained patents in England and Canada on this supporter, also another patent in the United States for improvements that have been made to meet the extended requirements for a high belt for floating kidney-ptosis, etc., with a minimum of pressure, heat and weight across the back of the patient.

Dr. Wm. Cowie of Guilford is still at the Paine Hospital, where he underwent an operation for appendicitis several weeks ago.

Dr. C. C. Hall, Jr., of Foxcroft has returned from New York, where he took a course at the post-graduate school.

Dr. Richardson of Bradford, Me., was a guest of the Piscataquis County Medical Society at Milo, Thursday, July 18th.

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VOL. III, No. 2

SEPT., 1912.

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Notice from members regarding sale of practice, merchandise, etc., should be sent in early and specify the number of insertions.

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VOL. III.

SEPT., 1912.

No. 2

THE CONSERVATION OF THE CARDIO VASCULAR SYSTEM.

H. AUGUSTUS MILLIKEN, M. D., HALLOWELL, ME.

Read before the 59th Annual Session of the Association at Augusta,
June, 1911.

In this era of commercialism when monetary values are placed on the productive capacity of man, which value differs not essentially from that which man places on his own beast of burden; or, as in slavery days did the planters at the auction block bid up the value or supposed value of each black, so we find ourselves in this generation doing the same thing only in a more scientific manner. However in each parallel it is a commercial estimate based on a monetary value. So it is in this generation in which we are now living commercialism has invaded and ramified into the utmost recesses of every trade and profession. It is the life and back bone of the times in which we live.

Medical research has for its ultimate results the prolongation of life which in turn increases the productive capacity which fact necessarily lessens the burden that the human family must carry. During the last decade, enormous strides of progress have been made in the conservation of life destruction by diseases due to organisms of bactericidal, protozoic and insecticidal origin. It is beyond the power

of statisticians to estimate the gap existing between our present state of longevity and that of a decade ago, and we may conservatively state that with new discoveries now in sight and with their practical application, the next decade promises to far excel that of the past.

It is only within a period of the few past years has any scientific attention been given to the conservation of the Cardiovascular system, and it is only of recent data that pathologists and clinicians began to seriously consider that in reality what was being studied as a variety of separate conditions were in part one pathological disease: namely, degeneration of the vascular system. So instead of taking up the several subjects of interstitial nephritis, aneurysm, cerebral hemorrhage, and some of the forms of infectious arthritis, and general or local arteriosclerosis, we may best consider them one disease with a common ethological and pathological origin. Accurate statistics as to life destruction from these various conditions, are difficult to obtain. Some authorities place it as high as eighty per cent of those living beyond the period of fifty-five, who succumb to some form or other of vascular degeneration. Every clinician knows how very important it is to be able to eliminate this disease in treatment of acute diseases during middle life.

In studying its future prevention, we must not forget the shadowy past in which the early clinician failed to diagnose tuberculosis until pronounced physical signs were present; and likewise did not recognize vascular disease until the arteries were beady and torturous; or in nephritic cases, the patient had become anemic with albumen in the urine, hypertrophy of the left ventricle of the heart, and the toxic symptoms of uremia were present. We now know that this nephritic picture just described was not one of recent origin, on the contrary, years have elapsed since its incipient symptoms appeared.

The onset of vascular disease is very insidious, and it can exist over a period of years without any very serious inconvenience. However, the cause of the disease can always be found if carefully looked for, the progress being held in abeyance to those bodies which are forever protecting the system against infectious and resulting toxemias. The loss in commercial value by this disease is enormous, effecting, as it does, largely the male element of the race, and, at a time in life when experience and study have culminated for their best productivity.

Unlike that great destroyer, tuberculosis, it does not seek the weak and improperly nourished person, on the contrary, evidence is abundant that the strong and over nourished are most susceptible to this disease, and thus we have a suggestive contrast. Broadly speaking, however, no one is immune from this disease, as it often times appears where it is least expected.

THE ETHOLOGY OF VASCULAR DEGENERATION,

Like many other diseases that have only been studied in part, it has until recently been shrouded in mystery, and it is because of this fact that such diversity of opinion has existed. Among the older causes, heredity stood out prominently, and without doubt certain families do show a predisposition toward this disease. It is a notable fact that the male strain of certain families predisposed toward vascular degeneration often succumb at middle age, while the female strain in the same families succumb much later in life, the same cause being responsible for death in each case, but at a varying period in life. This again emphasizes the fact of its preponderance in the male sex.

ALCOHOL, which has been deemed the cause of every disease where other causes could not be ascertained, has been pointed out to figure prominently in this disease, but a careful study of the drug will show that this line of reasoning is incorrect. That the only real harm alcohol can do is when its excessive use disorders the gastro intestinal digestion thus facilitating intestinal toxemia. Then again those preparations of alcohol which contain starches and sugars, namely, malt liquors and wines could be taken in excess of the digestive capacity of the diastatic enzymes, thus aiding in the production of an intestinal culture media.

INTESTINAL TOXEMIA.

Intestinal toxemia may be stated without qualification to play the most important part in the ethology of cardiovascular degeneration. Associated with this will always be found high blood pressure, putrefactive and infected stools, with an excess of indican in the urine. To analyze intestinal toxemias into its component parts at the present time is impossible. We must know more of proteid cleavage, the behaviour of certain bacteria, and the antiseptic action of certain enzymes on toxic products. However, the symptoms of intestinal toxemias are sufficiently uniform so that its existence may be recognized without any serious difficulty.

The clinical picture of this disease must be elicited from the patient by obtaining a careful history, and making a thorough physical examination. Heredity, age, mode of living and diet must be carefully considered.

Of the general symptoms fatigue may be mentioned as most constant. These patients tire easily, and their capacity for work is diminished. Irritability of the nervous system is usually present. Disturbances of digestion with flatulence and gases of which the odor of indol may be detected are excessively passed off from the bowels.

TOXIC PAINS in the muscles are frequently pronounced and they may affect any part of the body. There is indisposition toward hard work, and the patient is usually depressed in spirits. The history will show at this time that the quantity of urine in nephritic cases is increased and continues to do so with the co-incident increase of blood pressure. Excess of indican will be found by chemical test. The specific gravity is low and the color pale. Albumen is usually absent, but its presence is important as it may indicate the progress of the disease and the stage of advancement.

The examination of the stool is important.

Indol in excessive quantities is most constant.

Uncooked starches and cellulose, intermingled with excessive quantities of mucus are noticeable when a starchy diet is given in abundance.

Bacteria in excess of normal, causes the stool to ferment quickly after its passage and the odor is suggestive of putrefactive changes, and if indol is much in excess, the odor will be that of decomposing flesh. The action of the bowels is irregular, with a tendency toward diarrhea.

BLOOD PRESSURE, or vascular tension is a coincident symptom in intestinal toxemia. It may be taken by palpation which is a very unreliable method, but if used the following method is preferable. Grasp the patient's arm above the elbow with the right hand and make pressure over the brachial artery, while with the left index finger on the radial artery in the manner of taking the pulse. By shutting off the blood in the brachial and letting it on again, we may gain an approximate idea of the tension.

The use of the sphygmomanometer is the only correct method of testing out blood pressure, and is as essential in these cases as is the stethoscope in detecting a cardiac murmur. The normal blood pressure ranges from one hundred to one hundred and fifty millimeters, the average being about one hundred and thirty in adults. It is best taken in the recumbent position in which it is least, while in the standing position it is greatest. For comparison's sake, the same position should be used each time. In the early stages of these cases, the pressure will be found to be about one hundred and fifty millimeters, and at two hundred we may consider the condition extremely grave.

With these symptoms and conditions present the patient may go on for years alternating between better and worse until finally irreparable harm is done. The walls of the Vascular system become weakened, the left ventricle of the heart hypertrophies, thereby increasing the tension on the walls of the arteries. At the same time the elasticity of the whole vascular system is diminished. Na-

ture has exhausted her resources and the following sequelae soon develop.

Gradual dilation of some of the large blood vessels or aneurysms as we know it may occur. It will be recognized by its peculiar thrill on cardiac impulse. In nephritic cases, sclerotic kidney, uremic, common or cerebral hemorrhage may end the chapter. Or, in general systemic arteriosclerosis the end may be much deferred, but ill health and the ever embarrassing symptoms produced by a large heart and a non-elastic vascular system inconvenience the patient until somewhere usually in the brain the final lesion occurs, and if not immediately fatal means mental degeneration. The awful toll paid by these conditions can only be appreciated by studying the vital statistics of the various life insurance companies.

It will be readily understood that when we view cardiovascular degeneration from the standpoint of an infectious and toxic origin, how very important is the early diagnosis of the existing cause, since by its early correction it is possible to remedy these conditions before irreparable harm is done.

The essentials in every diagnosis lie in a thorough examination of the clinical history given by the patient. An examination of the stools for evidence of toxic changes. Of the urine for excessive indican, the quantity passed and the specific gravity. Remembering that in nephritic cases a large quantity of urine of low specific gravity without albumen always precedes intestinal nephritis.

The testing out of blood pressure by palpation or the sphygmomanometer, the latter method preferred. Should the examinations when completed show these conditions to exist, we are justified in making a diagnosis of conditions which preclude vascular degeneration, and like the incipient stages of tuberculosis this is the time to begin treatment. Nature at this time just as she helps combat the progress of tuberculosis will assist in correcting the infectious and toxic process going on in the intestine.

The treatment must necessarily be educational and corrective. The mode of living and its effect on the disease must be studied and corrected. No set rule can be followed. If indican exists and indol in large quantities is present in the stools, these being nitrogenous origin, the proteid digestion should be carefully looked after and it may be necessary to eliminate both simple and complex products from the diet.

The proteolytic enzymes should also be carefully investigated.

Again if starch is excessive especially should we be suspicious that it is uncooked. The cooking of the carbohydrates may often

explain this condition. At the same time the diastatic enzymes must receive attention. Bacteria we must remember is a factor in the putrefaction and the bile is a natural antiseptic and we should always avail ourselves of its use in intestinal infections.

Habits of living are very important. The human system is best served by doing the same thing every day. Physicians with their irregular habits are frequent subjects of Intestinal Toxemia, this fact figures prominently in the high mortality among medical men.

In closing this paper I wish to express my thanks for the interest you have shown in this important subject, and to express my opinion that I believe the future study of the conservation of the vascular system will be along these lines, just as we have had to educate them in the prevention of vascular disease.

The passage of our National Pure Food Law was a step in this direction. The establishment of a National Health Bureau will be another.

Medical men, however thankless the task may now seem, will continue to lead public sentiment in the right direction, and some time the public may appreciate what has been done and is being done to conserve their health. Certainly it would seem that the pecuniary sacrifice which the medical profession is making ought to be sufficient evidence that the motive in conservation is an unselfish one.

LEUKEMIA.

G. A. COOMBS, M. D., AUGUSTA, ME.

Read before the Augusta Medical Club, October 9, 1911.

DEFINITION.—Leukemia is a disease characterized by an enormous but fluctuating increase in the white blood corpuscles, decided decrease in the red corpuscles and hæmoglobin, and lesions of the spleen, lymphatic glands and bone marrow.

VARIETIES.—Two well defined clinical varieties are recognized:

(1) Splenomedullary or myelogenous leukemia and (2) lymphatic leukemia. The splenomedullary is much the more common type. Combined forms and variations frequently occur.

ETIOLOGY.—*Predisposing influences.* The disease occurs at all periods of life, but is more common between the ages of twenty and fifty. It is more common in males than females in the proportion of two to one.

Heredity apparently has some influence. Leukemia has been observed in successive generations and a leukemic mother has borne leukemic children; on the other hand leukemic mothers have borne non-leukemic children, and women showing no signs of the disease have borne leukemic children. Leukemia occurs in all countries and is not rare in the United States. During the ten years from 1901 to 1910, seventy-seven deaths from this disease in Maine were reported to the Secretary of the State Board of Health. In this series the proportion of males to females was almost precisely two to one. Other cases have undoubtedly occurred in which the diagnosis was not made. Cases have been observed in almost all kinds of domestic animals.

EXCITING CAUSE.—The actual cause is not yet known. It has been attributed to malaria and syphilis, but these probably have little influence in its etiology. It has followed splenic traumatism and grave bodily injury. Many observers consider it to be of microbic origin and this theory appears to be well founded, although no single micro-organism has been found. A case is on record, however, in which the attendant on a case of leukemia contracted the disease and died.

It has been held to be the result of the absorption of toxic substances from the digestive tract, which brings about a disordered condition of the blood making organs, and it is frequently associated with septic conditions of the mouth and ulcerative conditions of the intestines.

PATHOLOGY.—The body is usually emaciated, often extremely so. Edema of the subcutaneous tissues and transudates into the serous cavities are frequent.

In the splenomedullary form there is marked splenic enlargement, the organ sometimes weighing eighteen pounds, and is often adherent to the adjacent tissues. On section it is seen to be of a brownish color or mottled by lymphoid tumors of grayish or yellowish tinge; or by yellowish brown hemorrhagic infarcts. The microscope shows the condition to be hyperplasia. There are also changes in the bone marrow; which, instead of being fatty is yellowish green in color and resembles pus, or may be dark brown, and the bone is sometimes enlarged. There is usually some enlargement of the lymph glands. Lymphatic leukemia is characterized by hyperplasia of the lymphatic glands, usually with some splenic enlargement. Lymphatic tissue throughout the body, like tonsils, etc., may also take part in the hyperplastic process. The liver is usually enlarged, and, with the kidneys may be the seat of lymphatic infiltration and at times may contain distinct lymphatic growths, which have also been found in the stomach, omentum and even the skin.

SYMPTOMS.—The onset is gradual with pallor, palpitation, dyspnoea, progressive weakness, digestive disturbances and abdominal or glandular enlargement. Hemorrhage from the stomach may be one of the early symptoms, occasionally proving fatal before the patient's true condition is discovered.

Splenomedullary or myelogenous leukemia is the more common type of the disease and is characterized chiefly by splenic enlargement. The increase is gradual and pain and tenderness over that organ are sometimes present. It is usually painless, however. The enlarged spleen is usually palpable below the costal margin and sometimes extends to the public arch and beyond the median line.

Minor fluctuations in size may be observed; enlargement during digestion, and diminution during fasting and after diarrhea or free hemorrhage. Greater fluctuations frequently occur in the natural course of the disease or as a result of the administration of arsenic or other therapeutic measures. Massive splenic enlargement causes pressure symptoms, the more common of which are distress after eating and constipation. There may be ascites due to venous obstruction by the presence of the splenic tumor. Nausea and vomiting may be early and persistent, and diarrhea is common. The heart may be displaced upward by the enlarged spleen.

The pulse is usually rapid, soft and full. Edema of the lower limbs or general anasarca may be observed in the last stages. Hemorrhage is a common symptom. Epistaxis bleeding from gums, hematemesis, purpura, retinal hemorrhage and cerebral hemorrhage are frequent.

Deafness is sometimes present. There is occasionally moderate fever, sometimes reaching 103. The urine is not characteristic but usually contains an excess of uric acid. Priapism sometimes occurs and is probably due to thrombosis in the corpora cavernosa. It occurs so seldom in other diseases that this symptom alone should make us suspicious of leukemia, in the absence of venereal disease.

BLOOD.—In health the red blood corpuscles number about 4,500,000 in the female and 5,000,000 or 6,000,000 in the male per cubic millimeter. They are produced in the bone marrow, at first containing a nucleus. This is lost later, and the matured cells enter the blood as non-nucleated red blood corpuscles. In splenomedullary leukemia the red cells are reduced in number but not extremely so, the average being about 3,000,000. In the later stages and in severe cases the count may go below 1,000,000. Nucleated cells are numerous. These immature cells are not present in normal blood; their presence in any appreciable quantity indicating a pathological condition.

In health the white blood corpuscles number 5,000 to 10,000 per cubic millimeter and are made up of the following varieties: Polymorphonuclear ("polynuclear") 60-70%. Lymphocytes 20-30%. Eosinophiles, 3-4%. Mast cells less than 1%. Of these the lymphocytes are produced mainly in the lymphatic glands, the others in the bone marrow. In splenomedullary leukemia the white cells are enormously increased, even in the mild cases; from 100,000 to 200,000 in the early stages to over 1,000,000, occasionally, in the later stages. The number fluctuates widely and frequently, under the influence of arsenic or other therapeutic measures, are remarkably diminished, sometimes to normal. There are always myelocytes present however. These cells are characteristic and, in connection with the rest of the blood picture, pathognomonic. They are not present in normal blood. They are large mononuclear cells derived from the bone marrow and are embryonic or immature cells which normally mature before entering the blood as the polynuclear cells. They are found in great numbers in the spleen, lymph glands and liver. The polynuclear cells are increased in number, but their percentage is relatively low as is also that of the lymphocytes. The Eosinophiles and mast cells are usually increased both absolutely and relatively. The hemoglobin is considerably decreased usually to about fifty per cent or less.

LYMPHATIC LEUKEMIA.—The general symptoms are similar to those of the splenomedullary form. It is usually acute and rapidly fatal. It occurs more often in the young and is characterized particularly by enlargement of the superficial lymphatic glands. In its acute form it may resemble typhoid fever, sepsis or scurvy. The spleen and liver are usually only moderately enlarged. Occasionally the spleen is as large as in the splenomedullary form.

BLOOD.—In acute cases there is rapid diminution of the red cells, more marked than in the splenomedullary form and the haemoglobin is correspondingly low and nucleated cells are few. The white cells are increased but less than in the other type of the disease. Myelocytes are present but in very small numbers. There is a great increase in the large and small lymphocytes to over 90%, the normal being from 20 to 30%. The characteristic change is the great numbers of large lymphocytes. All other forms of white cells are relatively reduced.

In chronic lymphatic leukemia the blood changes are somewhat different. There is less reduction of red cells. Nucleated cells are rare. The increase of white cells affects the small lymphocytes chiefly, which are enormously increased. There is a growing belief that acute lymphatic leukemia is really myelogenous, the large lymphocytes being practically identical with the myelocytes.

This is still undecided, however, and I have grouped them according to the generally accepted classification.

SUMMARY OF BLOOD CHANGES. *Cabot.*

SPLENOMEDULLARY LEUKEMIA.

1. Red cells about 3,000,000, nucleated forms numerous.
2. White cells about 450,000, of which
3. Myelocytes form about 30%.
4. Every possible form of cell intermediate between the ordinary varieties is to be seen (Polymorphous blood).

ACUTE LYMPHATIC LEUKEMIA.

1. Red cells much diminished, nucleated forms infrequent.
2. Large lymphocytes predominate. Many of them often show degeneration.
3. Neutrophils and eosinophils very scanty.

CHRONIC LYMPHATIC LEUKEMIA.

1. Red cells about 3,000,000; nucleated forms rare.
2. White cells about 300,000, of which
3. Small lymphocytes usually form over 90%.
4. Myelocytes rare. Eosinophils scanty.

DIAGNOSIS.—The direct diagnosis can only be made by a microscopic examination of the blood. With an examination of this fluid, however, the diagnosis is easily made. The blood picture is so characteristic as to offer no excuse for failure to recognize leukemia when present. When the leucocyte count is more than thirty times greater than normal, the proportion of white to red cells one to fifteen or less, and myelocytes, large lymphocytes and nucleated red cells are present, the disease is always leukemia.

DIFFERENTIAL DIAGNOSIS.—The diagnosis between the two types of the disease can be made only by blood examination. In the splenomedullary form the blood is characterized by immense numbers of myelocytes and nucleated red cells. In the lymphatic form the blood is characterized by the excessive increase of lymphocytes; myelocytes and nucleated red cells being absent or present in very small numbers.

Leukemia is also to be differentiated from, (1) Hodgkins' disease, (2) tumors of spleen or kidney, (3) enlargement of lymphatic glands as a result of tuberculosis, syphilis or malignant disease, (4) hydro-nephrosis, (5) leucocytosis, (6) chronic malaria and (7) amyloid disease.

1. **HODGKINS' DISEASE.**—The pathology of Hodgkins' disease and leukemia are identical with the exception of the blood. In Hodg-

kins' disease the blood is normal or nearly so, or there is only moderate anaemia or leucocytosis.

2. TUMORS OF SPLEEN OR KIDNEY may be mistaken for leukemia, but there are no myelocytes present nor an increase of lymphocytes; the polynuclear variety only, being increased.

3. ADENITIS.—The blood is usually normal, or leucocytosis is moderate with an absence of myelocytes.

4. HYDRONEPHROSIS is sometimes mistaken for leukemia, but the blood is normal.

5. Leucocytosis of acute disease shows only polynuclear cells increased.

6-7. In chronic suppuration and malaria, anemia and leucocytosis are the only blood symptoms.

It will thus be seen that both the direct and differential diagnosis of leukemia is easy with an examination of the blood and this should be invariably done in suspected cases.

PROGNOSIS.—The prognosis is generally unfavorable, but remissions are frequent and a few cases of apparent recovery have been reported.

The acute lymphatic form is very fatal and usually runs a rapid course. The myelogenous form sometimes extends over a period of ten years or longer with remissions, and exacerbations.

Death usually takes place, however, within three years. Frequent hemorrhages, marked gastro intestinal disturbances, fever, anasarca, great enlargement of the spleen and progressive deterioration of the blood are of unfavorable significance.

TREATMENT.—Rest in bed, with plenty of fresh air and nourishing food are important. Of the drugs, arsenic is the most valuable and the one most frequently used. It is usually given in the form of Fowler's solution in ascending doses up to thirty minims three times a day. Iron is also useful and inhalations of oxygen are said to be beneficial. This should be employed daily in amount from five to twelve gallons.

Remarkable results have recently been achieved with the X-Ray and it should be employed in every case. Under its influence there is a decrease in the number of leucocytes and in the size of the spleen and lymphatic glands. With decrease of leucocytes there is increase of red blood cells and haemoglobin, and there is marked general improvement. The benefit seems to be produced mainly in the splenomedullary type. It is much less beneficial in the lymphatic, especially the acute. Arsenic may be employed at the same time but with great caution. At the first sign of chronic arsenical poisoning, the arsenic should be suspended at once as the eruptions may become

gangrenous under the action of the X-Ray. A high vacuum tube should be used to get penetration and the light should be applied over the spleen, enlarged glands, chest and limbs. The blood should be watched and the treatment stopped at the first signs of a crisis, or the presence of an increasing number of nucleated red cells. It is too early yet for a final conclusion as to the results of the X-Ray, but it certainly prolongs life and should be used as a routine in all cases.

Dr. Larrabee of Boston, has reported eighteen cases in which he used Coley's serum. The general condition improved markedly. The leucocytes were decreased in most cases. In others, they were not decreased but the general condition was improved. It seemed to benefit cases that the X-Ray did not help. He regards it as palliative rather than curative, but in many cases it may add to the life and comfort of the patient. It is a dangerous procedure and should be used with great caution.

It is important that the diagnosis should be made early in this disease in order to institute treatment as soon as possible. The patient should be kept under observation in cases of marked remissions and apparent cures in order to institute another course of treatment as soon as possible on the return of symptoms. Thus the patient may be kept in good condition and with fair earning capacity for years.

CONTAGIOUS DISEASES.

Read by Dr. George H. Coombs of Waldoboro, before the Sagadahoc County Medical Society, March 27th.

Let us consider the question of contagious diseases in their relation to us as physicians and to the public also the relation of the public to ourselves in these matters.

The law states "Whoever knows or has reason to believe," etc., shall give notice to the Board of Health. Why? In order that the public may be safeguarded and, if the party afflicted be unable to contract for medical attention, he shall receive proper care.

The law and the public, as a whole, recognize the physician as the expert in these matters as it does the civil engineer in questions calling for measurements of land, the lawyer in questions of law, the electricians in questions of electricity.

We as physicians have a double duty—first, to the patient and second, to the public. That we have a duty to ourselves, we recognize in the fulfillment of the above in good faith.

Our duty to the patient requires that we bring to him the best methods and remedies of the time, in order that the dread disease pass over quickly and leave not, in its course, a trail of death or injury which robs him of peace and comfort, depriving him of the ability to earn his own livelihood and care for those near and dear to him. To the public we occupy the sacred position of guardian from dangers of which they know not and which may come like a thing in the night to leave behind a never ending trail of human and financial loss more exhausting than all the wars of Christendom.

We must recognize the fact that these diseases will break out in any community and, while we are aware that modern methods of sanitation and treatment have robbed them of their virulence, yet we seem to be a long way from their total annihilation. We acknowledge that, by modern methods, we control the epidemics and, one by one, the scourges have been robbed of many of their terrors but there seems to be lacking something in the method, in execution and control which permits them to break out. That they do break out even in a mild form seems to me to be due either to ignorance or carelessness on the part of someone who is but little short of criminal.

Fear of disease or physical suffering is a strong element in the keeping of people away from a danger spot, but fear of financial loss and cowardly unwillingness to be discommoded is a strong factor in preventing proper measures being introduced in mild cases.

Because I am afflicted with a sore throat, which I hope may not be diphtheria, is no reason why I should not take advantage of all the resources available to ascertain if it be contagious. If it be contagious, I am, legally as well as morally, culpable if I have not tried every means in my power to prevent my neighbor from contracting the disease.

Why should we as physicians use every effort to get at a diagnosis and why should the public learn to take advantage of the knowledge in every instance? Because it is right and no other course is right.

Fear of quarantine with consequent loss of wages is a controlling factor that leads to concealment of mild cases. This very fear, added to the memory of harshness of methods of control in use in older days, is a potent factor in these situations.

By education of the public through the children and the daily press, sanitary methods will do much to overcome this.

There are certain developments in the care and control of these diseases which have become settled facts but they are nullified by falsifying and misconceptions, which are, primarily, the result of greed and cupidity on the part of some and fear on the part of others.

That scarlet fever, diphtheria, small pox, measles and whooping cough break out continually in any place is a disgrace to that community and some one or many are responsible.

The epidemics of scarlet fever seem to be much milder than formerly, but occasionally a severe case is observed.

A few years ago there were many mild cases in the city of Portland and it was a well known fact that a large number of them were not reported or quarantined and in many cases no doctor called.

A barrel of old clothing about that time, sent to an island settlement on our coast through coast missionaries, was followed by case after case of the disease, some mild and some severe—until the loss and suffering which fell upon those who received this clothing was a greater burden than the loss of a season's work.

I am sorry to feel obliged to believe that there are those who foster the idea that scarletina is a different disease from scarlet fever and that in mild cases they do not report them or take necessary measures.

It is not necessary that a whole household be quarantined for this disease. It would be possible to keep the patient away from the rest of the family and to destroy all discharges from the patient and see that all materials coming from the sick room are rendered harmless by disinfection.

In this disease and all others the daily home work of the nurse in these disinfections is more important than all else. They cannot live in filth during a six weeks' isolation and die, then, by discharging some disinfecting vapor in the room, render it safe from further contagion.

The element of early discharge from isolation in this disease is a more potent factor than any other in its spread. One has no right to "guess" because the case has been mild that a short period only is needed. Careful, painstaking examination of the entire body should be instituted and the duty of the patient and the public is not complete until this has been done.

We have at our command in the case of diphtheria methods of diagnosis and treatment which have changed the whole course of the disease. We have not fulfilled our duty unless we have adopted them. The doctor, whose years of work date back 10 or 15 years, knows but little of the ravages of diphtheria of 25 or more years ago nor does he know much of the squalor. Unfortunately, the public are gradually taking on an indifference to its seriousness quite similar to the attitude of many toward vaccination.

We have no excuse for not making cultures in suspicious cases of sore throat in order to get at our diagnosis, nor have we any excuse for waiting, before using antitoxin, for a report from this culture when we feel the diagnosis is fairly certain of diphtheria. No consideration of money, time, or physical weariness can mitigate our duty in giving such a patient antitoxin to the exclusion of all other work, for, the protection of the public by prompt isolation of all suspected cases is, absolutely, our first duty.

In addition, we are morally and legally bound to refuse to discharge these patients from care and quarantine until one and preferably two cultures have shown negative results.

The apparent mildness of measles and whooping cough lead many people from motives of personal convenience to sometimes move them long distances with or without the connivance and assistance of a physician.

Public and professional sentiment can do much to control this and I feel that one can hardly use too strong language in public or private in condemnation of these procedures.

Let us not compromise with these diseases and conditions because they are mild.

Let us frown upon—yes deride use of the terms “diphtheritic throat” and “scarletina” and “red rash” and “canker rash” and call it scarlet fever.

If it is the itch, let us call it the itch.

The largest portion of the public, lay and professional, who intend to do right because it is right, are morally and legally entitled to protection, and let us, by voice and deed, see to it that our sphere of influence is one of education of the individual to his duties and the public to the disgrace attaching to a community by the frequent outbreaks of these diseases.

“Behold what a great conflagration a small fire kindleth.”

We may dispute with the historian the relation between Mrs. O’Leary’s Cow and The Chicago Fire—but we cannot dispute the loss of life and property which followed an insignificant blaze.

Nor can we dispute the results of thorough work in New Orleans by Butler—in Memphis by Waring—in Cuba and the Philippines by Wood and in Panama by Gorgas, and if Panama, once the deadliest, can be made the healthiest section in the world, is it not a fair conclusion that the same results, with enormous advantages, can be attained in every community?

We, of these lands, are more than interested in small pox, vaccination and the venereal diseases and tuberculosis.

The results of vaccination are beyond dispute. Because an outbreak is mild should have no influence. All persons exposed should be isolated and vaccinated. Those who attend public meetings should be protected, from the unvaccinated, by their exclusion. While compulsory vaccination is repugnant to our ideas of personal liberty, those who, in times of danger, refuse to be vaccinated or allow their children to be protected in this way, should be forced by public sentiment to abide quietly by the rules which are laid down for them by those whose duty it is to protect the public.

I question if, in small communities, it is advisable for a physician to be a member of Board of Health, except in an advisory capacity, however desirable his services might be.

I believe the doctor can do more good in supporting the officers and in pointing the way to patient and public than through official work.

It is a curious thing how much of affairs medical a large proportion profess to know. Their book knowledge may be limited, but this medical lore is voluminous and powerful.

Their misunderstandings are responsible for the existence of many unhappy accidents and until they become better educated one idea must lie unattained.

In conclusion. It is a settled fact that these diseases can be absolutely eliminated. We believe that frequent outbreaks of any disease are unnecessary and in most cases due to carelessness but little short of criminal.

We believe in the immediate disinfection and destruction of discharges from these patients as soon as received and the gospel of the scrubbing brush instead of disinfection by the wholesale by noxious vapors at the end of the disease.

We believe our neighbor is morally and legally guilty if he permits a contagious disease to exist in his house without using every effort to ascertain what it is and to prevent its spread.

We know that vaccination has robbed small pox of its terrors and we believe those who do not by voice and deed sanction its use, are doing an injury to their neighbor and the public at large which cannot be estimated.

We believe every effort should be made to educate the masses and to bring home to those, who do not care, the idea that if these diseases may be confined to the houses in which they start and even to the one patient himself, that some one is surely and directly responsible if it go further and they are falling far short of their duty if they do not do their part to prevent any next case from ever occurring.

WORRY.

By W. F. HART, CAMDEN, ME.

Gentlemen of the Knox County Medical Society:—

I take this opportunity to call your attention to a subject that has not the honor of being listed in the catalogue of diseases. It is *Worry*.

From time to time during past centuries wise men who have delved in the secret of the working of the human mind have endeavored to enlighten man concerning it. Moral and religious teachers have tried to lead humanity out of it. Upon every side we hear "Don't worry!" "Why worry?" "It is no use to worry," and still even out of infants, we are fast developing past masters in the art of worrying.

If not always recognizing its harmfulness we all acknowledge its uselessness and yet continue to worry.

The moralist sees it from a religious point of view; the student of political economy from the profit and loss side; the physician from a hygienic standpoint. Both the religious and economic sides open up vast fields for thought, but as physicians we are more interested in the hygienic side of the question.

In past years physicians have been so engrossed in the search for specific remedies; in the development of serum therapy; in determining pathological change in diseased tissue; in short, so engrossed in studying organic diseases that the vast army of sufferers from functional disorders, so often dependent upon the habit of worry, has received but little consideration from the general practitioners. Too often for the honor of the medical profession has the unfortunate been told his troubles are all imaginary and if he would go home, stop worrying, and take care of himself he would be all right. This may be good advice and a truthful statement, yet no one with a harassed mind, suffering from more or less bodily discomfort can act upon it. Because the medical profession as a whole has not risen to its opportunity in handling this class of patients may be attributed the reason why we have so many religio-medical cults, such as the Christian Science, The Emanuel Movement, and the New Thought.

Of the various types of worries there is the *over-conscientious*. Every act and word in reference to his associates is a subject for his consideration. Its rightfulness or wrongfulness is held before some standard of justice and laboriously considered, and often some new subject demands attention before the first is satisfactorily settled. Too often this type is not only over-conscientious but also over-self-conscious, exacting, and domineering. Quick to take offence and very

exacting that others shall deal with absolute justice towards them. With a justice not necessarily according to general accepted ideas, but as they interpret it in accordance with their feelings. And of feeling they have a superabundance. They feel hurt, feel slighted, feel insulted, etc., to the end of the chapter. However deep their feelings, they surely cover the surface of the individual's life and even protrude so as to be in the way of more knocks than a boil on one's arm. To pose as a martyr feeds the vanity of such sufferers. Words however kindly spoken are often twisted from their intended meanings to show how they are abused and insulted. Suspicion runs riot with their judgment. People seen talking together are criticising them. If their society is not always sought they are not liked, and if attempt is made to cultivate it they suspect a selfish motive. While their mood is upon them they seem to derive a great deal of pleasure in being miserable. To attempt to explain a misunderstanding or to apologize at this time and retain one's self-respect is quite impossible. For each expression is keenly criticised to detect, not the kindness of the speaker, but the word or phrase that can possibly be so twisted as to convey an unkindness, thus trying to show how great a martyr he is by reason of the unjust opinions of others.

Closely allied with this group is the one who is continuously suffering perturbation of mind by reason of doubts. The "doubting folly" it has been termed. When in a normal mental condition one does many of the routine acts of business with no special thought. The busy housekeeper, for instance, day after day washes her dishes with no special thought or care, excepting, perhaps, a feeling of gladness when the job is done. Should she, however, become afflicted with an irritational fear of being poisoned by microbes, then what was a simple and almost thoughtless act becomes one demanding much mental action. As carefully as the work is first done she later is assailed with the fear she may have overlooked something and before her fears are allayed she has once more to do the job, if possible with greater thoughtfulness. The timid householder who just before retiring carefully fastens each door and window, then a little later, being assailed with the fear one may have been overlooked, gets up and again makes the rounds to each door and window, is well known.

I am reminded of a former neighbor of mine, a farmer and lumberman, who with his son, a man grown, would discuss for hours how to do some simple kind of work the most easily; and after the work was accomplished, often would doubt the wisdom of the method adopted and talk over how it would have been better to have done it some other way.

Dr. Walton, in his very interesting book "Why Worry," relates the instance of a young man who in his presence was actually fifteen minutes in buttoning his waistcoat. Thus he describes the act: "He felt the lower button to reassure himself, then proceeded to the next. He then returned to the lower one, either distrusting his previous observation, or fearing it had become unbuttoned. He then held the lower two with one hand while he buttoned the third with the other. When this point was reached, he called his sight to the aid of his feelings and glued his eyes to the lower while he buttoned the upper, unbuttoning many, meantime, to assure himself that he had buttoned them."

Though an extreme case, it will illustrate the danger that lies before one who habitually spends unduly anxious thought over the non-essentials of life. To the worrier it unfortunately is not always a question whether the thing has been done, and done in the best way, but to the conscientious worrier the moral question of right and wrong increase many fold the harassed state of mind. "Ought or ought not I to do this" is a question legitimately asked when it concerns a subject of vital importance, but when continuously applied to the un-essentials it immensely adds to one's mental burden. By thus taking so serious a view of life, we see a reason for the development of another type of worriers, the melancholiac.

As we view an extreme case of this type, we have a living illustration of how much unhappiness can be crowded into one's life. This case came to my notice. A young woman of twenty-six, belonging to the laboring class, for five months had confined herself to her room, most of the time in bed. Depression of spirits was so marked as to almost constitute insanity. Past good health, pleasant family relation, ability to work, etc., were continually in mind only to intensify her present state of wretchedness. To weep was far easier than to eat. Untidiness of room and of person was more congenial to her feelings than the reverse. Efforts to arouse hope for better things seemed to fix her mind more intently upon how much better life used to be. The joy of living today and of entertaining bright hopes for the future seemed as unattainable to her as though shut out by an impenetrable wall.

This extreme case, fortunately, is not typical of the masses who are suffering from melancholia, but it serves to illustrate the condition toward which all are tending, who, blind to the blessings of life, dwell upon its sorrows and hardships.

As worthy associates and boon companions of the melancholiac we have the hypochondriac and the neurasthenic.

The former by an unduly solicitous care over some physical ill, real or imaginary, becomes more or less of an invalid. Anything short of perfection in the workings of the various organs fills his mind with fear and unrest. So over solicitous is he, as regards his physical condition, that a failure of the bowels to act with their accustomed vigor at the usual hour is enough to fill him with alarm. Sensations which to the normal mind would not occasion a second thought to him are evidence of some deeply seated organic disease. Knowing how the attention fixed upon the body will in the neurotic give rise to various feelings, we see how one of this nature is constantly afflicted. By his constant self-study and being unable to correctly analyze his own feelings, he in time comes to know so much about himself which is not true that it would fill a large volume.

The neuresthenic is not strictly in a class by himself, for the term neuresthenic may include all the various types of worriers, but here we refer to those who are suffering from neuresthenia. The term, as generally used is signifying nervous exhaustion, is sometimes referred to as the fashionable disease, and yet by no means confined to the aristocracy. Many a conscientious hard working man or woman, as a result of too long application to business, has become its victim. As we study the whole class, however, we find a large percentage suffering from all the phenomena of nerve exhaustion as the result of faulty mental action and introspection. The one whose financial and social condition is such that his principal business is hunting after enjoyment and who deems it far more important to be feeling well than doing well is especially liable to join the army of invalids. The headache following an evening's entertainment with a midnight supper; palpitation of the heart arising from a too hearty meal, or some other abnormal feeling though trivial in character, is enough to give rise to a fear that leads to anxious self-study with nullification of bad feelings and all the attending features of a nervous breakdown. Likewise with the laborer and business man when the fear of not attaining that to which ambition leads them, or anxiety about threatening financial obligation, or the annoyances of incompetent subordinate, etc., is added to their all ready busy minds, then they too are in danger of increasing the number of unfortunates.

Worry as defined by the century dictionary is "harassing anxiety, solicitude or turmoil; perplexity arising from over-anxiety or petty annoyances and cares." This tells what it is, but by studying the different types of worriers we can come to a more comprehensive understanding of what it is; or we can, at least, see how the human being considered as a machine, grinds out its grist of worry.

First we notice there is present in each one some idea or thought that is not only insistent but unduly so. So intense is the ruling thought that it can be called an obsession. In the superconscious, the fear of not having done right, or of not doing right hangs like a nightmare over him, robbing him of peace of mind and impairing his ability to work. Though the subject be trivial it has to be weighed in the scales of justice with the same care as more important ones. This is also largely true of the over afflicted with doubting folly. We see it manifested in his fear that he did not properly address a friend or a stranger; that he made a mistake in accepting an offer, fearing he will not do the work properly; that it will not be right if he does this or if he does that. We also find him obsessed to want to understand the reason for everything.

I wonder if you ever had your patience tried by a doubting neurosthenic. Possibly he comes to your office complaining of discomfort through the chest and of having, at times, palpitation of the heart. After looking him over carefully and getting his history you tell him his troubles arise from imperfect digestion.

But doctor, don't heart disease cause the same symptoms? you have to acknowledge it may.

Well then, are you sure my heart is not diseased?

In accordance with the best evidence attainable, you assure him it is not.

Yes, but do you think you have all the evidence?

And thus it goes on, question after question; patient finally departing not satisfied as to his real condition, and you weary and feeling about as small as three cents.

The obsession of the hypochondriac is that every function and feeling of the body shall be perfectly normal. In fact the study of these things in reference to effect on his health is what makes him a hypochondriac.

As important as these obsessions are in developing the worrier they are subordinate to that of egoism and exaggerated self-conscientiousness.

If not the center of the universe he is at least the hub around which everything associated with himself revolves. If he undertakes a piece of work, enters upon any recreation, attends a social gathering, or if he goes to church, theatre or any other place, there is always the question as to the effect upon himself. He anxiously studies every act that may be more or less public that people may think well of him. He spends hours thinking what others will say of him if he does so and so. In public places every one, in his imagination, sees him. If he stays at home all his acquaintances make comments. Should he

perchance do anything out of the ordinary—however trivial—he is thrown into a whirlpool of doubts and fears of what people will say.

Recently I saw a lady suffering great perturbation of mind because on presenting a check at the bank to be cashed, she was informed she would have to be identified first. It did not occur to her that the bank could make no exception in her individual case.

If we fix our eyes intently upon a cent held just in front of us the cent is plainly seen but the whole world—excepting a few things close at hand dimly outlined—is shut out. Now if we change the focus of our eyes, looking beyond the cent, the broad expanse of the universe is spread out before us while the cent in its turn is but dimly seen.

This is what the egoism of the worrier compels him to do. Self, like the cent, is held up before the mind's eye and with the mind intently fixed upon it, the whole world as pertains to business, comforts of home, enjoyment of health, of social life, etc., is but dimly discerned. Self, however, becomes to him the whole world. But instead of seeing the pleasant homes dotting the hill-sides, the beautiful expanse of field, meadow and forest, with here a lake and there a stream; instead of seeing the birds as they flit hither and yon; instead of seeing the enormous industries of man, magnificent buildings and philanthropic enterprises; instead of seeing the bright rainbow of promise, he sees what? Simply self,—self torn by conflicting opinions and harassed by aching nerves.

How, we may well ask, is this vast army being recruited. I have already said that even out of infants we are making pastmasters in the art of worrying. One of the child's earliest recollections is his mother's fear that he will take cold. Then he soon learns, usually from the same source, that by reason of some individual peculiarity he can not eat certain articles of food ordinarily suitable for his use. From the child thus influenced by the fear of taking cold, we see developing the adult who is unduly solicitous concerning his physical condition. To impress upon the child false ideas concerning himself, whether it be in regard to eating or anything else, is simply paving the way for greater mental annoyances later in life. The child may be born into a home where the very atmosphere is pregnant with worry. Mother worries about the children's clothes, father's dinner, grocer's bill and the rent. She worries about the neighbors across the way, about the demands of society, etc. The whole family tendency is to be reaching anxiously forward into the future; and business cares are so intimately woven into the family life as to destroy much of its rightful peace and happiness. In such homes as these, we often find children under ten years of age looking upon life with undue seriousness.

and having the idea that to worry about everything is one of the necessities of correct living.

Another method of developing the habit of worry is by not keeping the mind and body working together harmoniously, or by living too much in the future. When we have work to do, whether it be planting corn, building a house, going on a journey, or whatever we are doing that has a time limit, we see it completed, mentally, long before it is accomplished. Routine work, work that is found in all kinds of business, work that, in itself, does not seem to amount to much, and yet is essential to the completion of the whole, we all are too apt to hasten in doing in order to overtake the mind which, from the beginning, has been busy with the more important part of our business. For illustration, we can, in our imagination, see the mind as an entity by itself quickly outstripping in the race the more cumbersome body, and then standing first on one foot and then on the other while it impatiently awaits the coming of the hurrying, hustling body. When, with these reasons, we take into consideration close business competition, demands of civic and social life, increased cost of living without adequate increase in wages, we find sufficient reason why worry prevails so extensively, and perceive the mighty forces to be overcome before it can be subdued.

When we consider how puny is the effect of the average man compared with that required to turn mankind from its faulty mental habits, it is with diffidence we say anything concerning the treatment of worry. Indeed we almost question if it is not best to leave those who worry and who are suffering from its effects in the hands of the various religio-medical cults, or consign them to the tender mercies of quacks of whatever name and nature. As, however, it is possible under rational methods for mankind to free itself from this burden, it should be deemed a privilege by the medical profession to point out the way.

In the early days of the Christian era, such philosophers as Epicurus and Marcus Aurelius moralized over this same subject. From the latter we gather the following: Begin the morning by saying to thyself, I shall meet with the busybody, the ungrateful, arrogant, deceitful, envious, unsocial. All these things happen to them by reason of their ignorance of what is good and evil." . . .

"Do not disturb thyself by thinking of the whole of thy life. Let not thy thoughts at once embrace all the various troubles which thou mayest expect to befall thee; but on every occasion, ask thyself, What is there in this which is intolerable and past bearing? for thou wilt be ashamed to confess. In the next place, remember that neither the future nor the past pains thee, but only the present."

"When another blames thee or hates thee, or when men say anything injurious, approach their poor souls, penetrate within, and see what kind of men they are. Thou wilt discover that there is no reason to take any trouble that these men may have this or that opinion about thee." And again we find: "Let not future things disturb thee, for thou wilt come to them, if it shall be necessary, having with thee the same reason which now thou usest for present things."

From these and other like sayings, the author would teach how by the exercise of reason, one is enabled to maintain a tranquil mind; how, by attending to present duties and troubles, much mental annoyance is avoided. He teaches the honest self-conscious soul the unprofitableness of being disturbed by criticisms from the ignorant and vicious and teaches all of us the folly of borrowing trouble.

From the greatest of all moral and spiritual teachers, the Christ, we get the keynote and inspiration that have prompted all homeless on worry. It is faith and self-forgetfulness. A self-forgetfulness as is manifested in one's love for all mankind and an interest in things outside of self.

To think of one, as being filled with worry, who has a living faith in the over-ruling providence of God; who, while in the active enjoyment of his own business, abounds in good works towards his fellowmen; who has his mind, not so intently fixed upon business, but that he can literally consider the "flowers of the field" and the "birds of the air;" who patiently follows his way of right living to the end, is impossible. As man, however, has not universally incorporated into his life the teachings of the Great Master, we have to learn the reason and common sense of how to overcome worry.

Prophylactically, we would begin with the child. Have him live a simple, natural life, breathing an atmosphere pregnant with hope and confidence; and living in a home where the members of the family have respect and consideration for one another. Should he show a disinclination to partake of food suitable for one of his age, teach him that food is not eaten primarily to give pleasure but to nourish the body. Guard against his forming that belief which is too often held by adults, viz.—that he can't eat certain kinds of food, for such a belief formed early in life may be the first step in the growth of many obsessions that later in life harass the individual. Teach him that far more important than dress and society, is character, and that to meet disappointment with self-control is the proper thing. Thus trained, one in mature years is better able to preserve, under all conditions, a calm and tranquil mind.

As cares and responsibilities of life are encountered, he almost intuitively acquires the habit of keeping the mind fixed upon the present duty, giving no anxious thought to those to come.

How not to work can be learned by observing the average boy who is obliged to saw a certain amount of wood before he can attend the ball game.

With collar unbuttoned, sleeves rolled up, he, with might and main, drives the saw through stick after stick. From the beginning he has no interest in how the work is done excepting how quickly. His mind instead of being in a condition of repose, or instead of viewing with pleasure the progress of the work, is impatiently driving the body to greater exertion while picturing to itself the exciting pleasure of the game.

However fanciful the picture here drawn, it serves to illustrate how mental energy can be wasted even in the performance of very simple work. If, in little things then, one is to maintain a mental equipoise, how essential that he cultivates the habit of working hand and brain together, giving to the present subject its due amount of thought, and thus being better able to take up subsequent duties with the mind in its best condition.

In treating a well developed case of worry some other method than that of giving the admonition "Don't worry" must be adapted to be successful. The one who has succeeded in overcoming the habit realizes the magnitude of the undertaking. The two underlying factors of worry, the "unduly insistent thought" and "exaggerated self-consciousness" have become so interwoven with the individual's life as to have become a part of himself, and only by long and persistent effort can they be rooted out. Medicine has its uses in overcoming physical ills, but for the cure of obsessions and egoisms, the products of years of faulty mental habits, self-discipline alone is the sovereign remedy. Though obsessions be as varied as there are different individuals yet, in order to walk in the fulness of mental liberty, one must overcome the one or more that restrains him.

Is it that every thing must be done with exactness? If so, remember many things are too trivial to demand undue thought and to give to each subject only that which the time and place legitimately demands.

Is it that we can sleep only when conditions are just right for our peculiar temperament? Then remember that regardless of temperament one can sleep under any ordinary condition and, furthermore, remember that the loss of a night's sleep occasionally is of far less importance than the fear of not sleeping, which in itself often keeps one awake. Is it a noise, position of the bed, strangeness of the surroundings that prevent our sleeping? If so we will place ourselves in a restful position and cease to think of the noise or other disturbing influ-

ence. If we can't stop thinking we will endeavor to concentrate our thought on some other subject than that which disturbs, or which is even better, we will with body and mind relaxed, avail ourselves of the suggestion "I can sleep." To sleep or not to sleep will often depend upon the condition of mind indicated by the presence or absence of an apostrophe and t ('t) with the word *can* in the sentence "I can sleep."

In all obsessions which fret and annoy, whether they be trivial such as I can't endure certain odors, I can't endure the presence of one chewing gum, I can't go into a hall where there is a crowd, etc., or whether they be more important ones associated with business we should learn that the opposite is true.

That *self* of ours which to us has become of so great importance should learn that it is but one of a great many, and that in the world at large it averages the same amount of attention as every other self. As it learns this, it will be more easy to discard the idea that itself is a special object of observation and comment.

We should remember that a joking remark or a passing criticism contains no malice and is soon forgotten by the maker, and furthermore is nothing more than what every other individual receives. Cease to worship self and do not expect others to render it homage.

Avoid introspection, that anxiously inquiring attitude of mind, to determine what effect every act and condition of life will have on one's self. With all these, if we cultivate the underlying principles of Christian living, viz: self-abnegation and brotherly love, we shall be free from the ravages of worry.

The treatment for ills arising from worry is that for *neurasthenia* and I will not further weary you by giving it. I wish, however, to make a brief plea for this class of patients. They are unfortunate and in many cases have arrived at their present deplorable condition through great mental suffering. That its occasion was more imaginary than real does not lessen the fact of suffering. As patients, they are as worthy of consideration as any of humanity's unfortunates and should not be lightly dismissed with the statement "There is nothing the trouble with you, go home, keep up courage, and you will be all right."

Though imaginary, their bad feelings are a living vital reality that should be relieved. To furnish their relief, enabling them once more to resume proper places in their families and to become useful members of society, requires something more than a science, it is an *art*.

SURGICAL SUGGESTIONS.

A biliary fistula with patent cystic and common ducts may be used as a means of introducing medicaments or fluids into the bile tract or upper bowel. —*American Journal of Surgery*.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

May Bulletin of Maine Agricultural Experiment Station.

The contents of the May bulletin issued from the Maine agricultural experiment station is devoted to the results of official inspections made of the following drugs: sweet spirits of nitre, tincture of iodine, sweet oil and black antimony, which were purchased of various druggists, grocers and other dealers in different parts of the State, during the winter of 1912.

The method of preparation and preservation of sweet spirits of nitre is entered into carefully and many useful suggestions are offered and the conclusion drawn that under conditions that can be readily imitated in any drug store sweet spirits of nitre may even, in summer, be kept without deterioration for sixty days and in good condition for ninety days. The recommendation is made that the date of preparation be stamped on the bottle of the dealer and the date after which the drug should not be used on the bottle delivered to the consumer. A table is presented giving the names of the dealers from which this article was purchased, the price paid per four ounces, the percentage of ethyl nitrate present and the strength of the various samples as measured by the U. S. P. standard. The cost varied from ten to forty cents. The strength from twenty-five to one hundred and thirty per cent in samples purchased at drug stores, but in the case of certain goods bought in bulk, not even a trace of the original

spirits of nitrous ether was found. "The samples taken show a great improvement in the quality of this drug dispensed by the drug stores throughout this State.

In 1908, before the directions for preparation and storage were published, even the best druggists were frequently found at fault as to the strength of the spirits of nitrous ether dispensed. While there is still room for improvement, the situation is encouraging as only four of the samples selected during the past winter were less than three-fourths the standard strength." The work of the Maine Experiment Station is to be highly commended for its endeavor to secure to the physicians and public a more uniform strength and better quality of drugs dispensed, and its investigations are heartily welcomed by the better class of druggists who are desirous of furnishing their customers with products of standard strength.

Medical Defense Fund.

"The ruling of the State superintendent of insurance (Missouri) prohibiting companies from writing defense insurance for physicians has caused a great deal of comment among members of the Association, both as legality of the order and as to what effect it will have on the status of our own defense measure. We are advised that the ruling cannot affect our Association and the members therefore will continue to receive the assistance of the Association in all mal-practice suits of a civil character.

The uncertainty of the legal status of insurance companies in this respect has revived the agitation among the members for an extension of the defense benefit of membership in the Association. It seems to be an opportune time for considering this question seriously, with the view of enlarging the fund and increasing the benefits." — (*Iowa Medical Journal.*)

It is interesting to note that, in some few States, similar action to the above is being taken and, unless something is done to forestall activities along this line, we shall have to face this question in Maine. The Medical Defense Fund has offered the only rational solution up to the present time. It is true that it does not supplant the physicians' Liability Policy, in that, it does not pay any indemnity in the loss of a case, but merely supplying defense at no cost to the physician.

This year, the State Association was in a better position to undertake this line of work than it will be again for some time, nevertheless, the fact remains that eventually it will be compelled to do so in order to protect its members from blackmail.

The reports received from the various States, where the Defense Fund is in operation, are amply convincing of the success of such a measure, moreover, it is operating successfully in the majority of States which is convincing proof of its efficiency, but when we add to this, the possibility of having to face some measure which will eradicate our present Protective Insurance Policies, it then becomes imperative to consider some such action.

We are advised that this matter will be resubmitted to the Counties during the year and will come up for action at the next regular State Meeting and we would suggest that those who are opposed to this measure on grounds which are not amply clear to themselves would take the time to look into the matter fully as it merits most careful consideration of both its advocates and its opponents.

Medico — Legal Department.

The Journal will devote, in the forthcoming issues, a portion of its space to the presentation of matters of a medico-legal nature, endeavoring to set forth extracts from existing laws bearing upon many of the subjects that arise in the practice of every physician throughout the State of Maine.

In a country where the sovereign rule of the various States has always been held of so much importance, it is obvious that the regulation of most questions of a medico-legal nature are to be settled by the legislators and judiciary of the various States, and so we find that in certain particulars each State may enforce laws somewhat different from those of her sister States.

The State of Maine, on account of its geographical position, situated as it is on the North Atlantic seaboard with its hundreds of miles of indented coast line, furnishing harbors that invite the commerce of foreign nations, its myriads of islands and inland-lake shores peopled with pleasure seekers, and the refuge for thousands in search of health, its great northern boundary projecting wedge-like into the vastness of the Dominion of Canada, its cities teeming with a population in daily interchange with settlements of the Canadian provinces, communities governed by laws radically different from ours, makes for a condition that would obviously need statutes differing materially from those adapted to many other States.

It is hoped that a page devoted to such important questions as the statutes governing quarantine, state and local boards of health, water supply and sewage, disinfection, vaccination, vital statistics, communicable diseases, medical examiners, coroners and undertakers, autopsies, anatomical material, pauper laws, mal-practice, criminal abortions, rape, commitment of the insane and many others, may make accessible to the busy practitioner a certain amount of valuable material.

Midol and Nurito — Two New "Patent Medicines."

As physicians are often asked in regard to the composition of "patent medicines," the report of an analysis of two new arrivals reported by the A. M. A. Chemical Laboratory is of interest. This report shows that pyramidon, a product very similar to antipyrin and until now an "ethical" preparation, has entered the "patent medicine" field.

Midol, according to the association's chemists consists of tablets which contain as their essential ingredient about five grains of pyramidon.

Nurito, according to the chemists, comes in the form of powders each of which consists essentially of pyramidon, six and two-thirds grains, phenolphthalein, two-thirds grain, and milk sugar, two and two-thirds grains. While according to some, pyramidon is less depressant than acetanilid, phenacetin and even antipyrin, the promiscuous use of the remedy is to be discouraged, of course. When it is remembered that the indiscriminate use of acetanilid was needed to emphasize its dangers, so the abuse of pyramidon will no doubt make its toxicology better known. (Jour. A. M. A., Aug. 10, 1912, p. 461.)

National Society of Anesthetists.

On June 6th, at Atlantic City, during the meeting of the American Medical Association and following a symposium on anesthesia, the National Society of Anesthetists was organized. Prof. Yandel Henderson of Yale, Chairman of the commission on anesthesia of the A. M. A. occupying the chair, those assembled for the symposium acting as a committee of the whole, proceeded to organization, and elected the following officers for the year 1912-1913:—President, James T. Gwathmey of New York; Vice-Presidents, Charles K. Teter of Cleveland, F. H. McMeechan of Cincinnati, Yandel Henderson of New Haven; Secretary, William C. Woolsey, 88 Lafayette Avenue, Brooklyn; Treasurer, Harold A. Sanders of Brooklyn.

The constitution and by-laws were ordered to be drawn by the executive committee and submitted to the Society at its next meeting for adoption; all names submitted for membership, if qualified in the estimation of the executive committee, shall be considered as charter members if presented within a period of sixty days and accompanied by the levied due of three dollars.

The National Society of Anesthetists in this notice, calls all those who are actively interested in this work, to join its ranks and assist in developing the subject of anesthesia to greater perfection and more uniform safety.

WILLIAM C. WOOLSEY,

Secretary.

June 10th, 1912.

Calcium Glycerophosphate.

The glycerophosphates have come into rather wide use during the last twenty years. This use was based on the belief that because of the chemical relation between glycerophosphates and lecithin, the former were more readily assimilable than inorganic phosphorus compounds. While the evidence for the value of glycerophosphates was not altogether satisfactory, it was considered sufficient to give these products a place among the remedies of possible value and, therefore, the council decided to describe calcium glycerophosphate in new and non-official remedies. Since the council reached this decision, experiments by Fingerling (G. Fingerling, *Biochem. Ztschr.* 1912, xxxviii, 448, xxxix, 239) McCollum and Halpin (E. V. McCollum, and J. G. Halpin, *Jour. Biol. Chem.*, 1912, xi, xiii) and others have shown that animals can form organic phosphorus compounds (lecithin, neucleoproteids, etc.) out of inorganic phosphates quite as readily as from organic phosphorus compounds. Hence, it is probable that the glycerophosphates are of no more value in phosphorus metabolism than the inorganic phosphorus compounds.

At the request of the council the Association's Chemical Laboratory took up the examination of the several brands of calcium glycerophosphates as found on the market. The comprehensive report of this examination (*Jour. A. M. A.*, July 13, 1912, p. 134) shows that the product is of a very poor grade and that none of the manufacturers appear to be willing or able to promise an improvement of the product. The report of the laboratory concludes that all of the specimens were decidedly impure in one or more particulars. On comparing the results found in the examination with the standards prescribed in the foreign pharmacopœias and pharmaceutical commentaries—there is no American standard—it was found that none of the specimens complied with all of the requirements in any one of these authorities.

In view of the findings of the laboratory the referee of the council's committee which had the matter in hand submitted the following recommendations which were agreed to by the council:

"Thus, according to this examination the market supply, including the proprietary brand 'Lime Tonol' for which extravagant claims of purity have been made, are all of inferior quality. The products contain considerable quantities of impurities such as sulphates, chlorides, and foreign sodium and calcium compounds, the presence of the latter in most cases having been disguised by the addition of citric acid. The composition is such that none of the products on the American market is entitled to the name 'calcium glycerophosphate.' The

report also shows that while the manufacturers have in general acknowledged the poor quality of their product, they have shown considerable indifference concerning its improvement. Since they have been unable or unwilling in the past to supply calcium glycerophosphate of fair quality, there is little likelihood that a decreased demand which may be expected since the demonstration of its small value will offer an inducement to improve the quality in the future. In view of these conditions, it is recommended that calcium glycerophosphate be not described in New and Nonofficial Remedies."

Disposal of Offal.

At this season of the year when gastro-intestinal disorders are most prone to occur owing to the increasing temperature furnishing an atmosphere particularly favorable to the growth of bacteria, insects and their larvae, and to the combined physical, chemical and bacterial changes incident to decomposition, fermentation and putrefaction, the dust of unholed streets raised in clouds by winds and rubber-shod six cylinder Juggernauts, laden with its millions of bacteria, scattered over the market place descending upon fruits and vegetables, many of which in the past have been displayed without being properly protected, when myriads of house flies, that Dr. Jekyll and Mr. Hyde of domestic pets, which we find equally at home cavorting among the garbage pails, sputa, excreta and what not of a side alley or on the most immaculate table linen of the dining room or the choicest viands from the kitchen and to this add the fact that yearly hundreds of people seeking recreation and health, some of whom may be typhoid carriers, are found dwelling on the shores and bathing in the lakes that furnish drinking water for unwary thousands, would perhaps afford sufficient reason for introducing in this issue of the Journal certain laws dealing with the disposal of offal and looking to the protection of public water supplies.

SURGICAL SUGGESTIONS.

The history of a fairly sudden enlargement of a testicle does not necessarily mean an inflammatory or traumatic process. Such an enlargement may be due to spontaneous hemorrhage in a round-cell sarcoma of the organ.—*American Journal of Surgery*.

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A. B., care Maine Medical Journal.

Medico-Legal Matters.

Pollution of Water.

"Whoever knowingly and willingly poisons, defiles or in any way corrupts the waters of any well, spring, brook, lake, pond, river or reservoir, used for domestic purposes for man or beast, or knowingly corrupts the sources of any public water supply, or the tributaries of said sources of supply in such manner as to affect the purity of the water so supplied, or knowingly defiles such water in any manner, whether the same be frozen or not, or puts the carcass of any dead animal or other offensive material into said waters, or upon the ice thereof, shall be punished by a fine not exceeding one thousand dollars, or by imprisonment not exceeding one year."

R. S., Chap. 129. Section as amended by Chap. 104 of Laws of 1907.

This law forbids the pollution of water used for domestic purposes by either man or beast. It affects private as well as public water supplies. While laying a great deal of stress upon the doctrine of intention and holding him specially guilty who *knowingly* corrupts the water supply of others, it is also operative against anyone who throws carcasses or "other offensive material" into such waters.

The fool therefore will suffer along with the knave.

It is curious to notice the distinction between "corrupt" and "defile" as applied to public water supplies.

The former apparently refers to putrefying substances in such quantity as to affect the purity of the water. This is of course a scientific question. The larger the volume of water and the more it is agitated by wind and wave the sooner will it purify itself.

As to defilement, there are other sources than putrescence. As for instance the chemical waste from mills, and sawdust.

The principal sources of water pollution are therefore sewage, decaying animal or vegetable matter, chemicals and sawdust. Much disease, and especially typhoid fever would be prevented if it were made obligatory upon water companies to first pass their water through sand filters, before delivering it into the mains for public consumption.

The Collection of Offal.

The ordinances of the City of Portland for the collection of offal are as follows:

SEC. 4. All dirt, sawdust, soot, ashes, cinders, shavings, hair, shreds, manure, oyster, clam or lobster shells or any animal or veg-

etable substance or filth of any kind, in any house, warehouse, cellar, yard, or other place which the mayor, any alderman, chief or captain of police, or board of health shall deem necessary for the health of the city to be removed, shall be carried away therefrom, by and at the expense of the owner or occupant of such house or other place where the same shall be found, and removed to such place as shall be directed, within four hours after notice in writing to that effect, given by the mayor, any alderman, chief of police, captain of police, or board of health.

SEC. 3. Any accumulation of refuse matter, such as swill, waste of meat, fish or shells, bones, decayed vegetables, dead carcasses, excrement or any kind of offal which may decompose and generate disease germs or unhealthy gases and thus affect the purity of the air in the immediate vicinity of any dwelling house or place of business, shall be considered a nuisance, and must be removed or disposed of either by burial, burning or otherwise, and in such manner that it may not be offensive to the neighborhood wherever located.

HIGH-POTENCY ANTITOXIN.

A noticeable preference for concentrated antidiphtheric serum (globulin), as compared with the older or "regular" form of diphtheria antitoxin, has manifested itself among the medical fraternity. "High potency, small bulk," appears to be the order of the day. A good index to the tendency in this direction may be found in the offerings of the manufacturers, who, as a matter of course, are promptly responsive to each new demand of the profession. For confirmation of the belief that the concentrated product is now in the ascendancy, one has but to turn to the announcement of Parke, Davis & Co. in the current number of this journal, "Antitoxin That Justifies Your Confidence." Here one finds prominently featured the concentrated antidiphtheric serum (or globulin). It is interesting to note in this connection that a wider range of dosage than formerly is now offered—from 500 to 10,000 antitoxic units—the larger doses, of course, being provided for severe, late or other exceptional cases. And herein, at least, is one undisputed point in favor of the concentrated antitoxin: when a large dose is needed, it can be administered in this form without difficulty and with little danger of disturbance, owing to the comparative smallness of its bulk.

Some physicians, it may be noted, are under a misapprehension as to the nature of the concentrated antidiphtheric serum (globulin), assuming that it is widely different from the product which they have known for years as antidiphtheric serum. The idea is wholly erroneous. Concentrated antidiphtheric serum (globulin) is the regular product, precipitated and purified, from which most of the serum constituents have been eliminated except those bearing the antitoxin. It is in no sense inferior to the original serum—on the contrary, as previously noted, it possesses the advantage of lesser bulk.

Review of Current Literature.

(Journal of Ophthalmology and Oto-Laryngology, February, 1912.)

Practical Points in the Surgical Treatment of Exophthalmic Goitre.

A. J. Ochsner, B. S., M. D., F. R., M. S., LL. D., Surgeon-in-Chief, Augustana Hospital and St. Mary's Hospital; Professor of Clinical Surgery in the Medical Department of the University of Chicago, Ill.

Attention is called to the fact that when any disease is transferred from the field of internal, to that of surgical, treatment, much confusion naturally arises, because surgical interference is then thought to be the choice of procedure in every case. This erroneous conception leads to two opposite mistakes; namely, the operating on cases capable of recovering spontaneously, and operating on cases unable to bear the shock of an operation in addition to that of an acute attack. All these facts are true in regard to the surgical treatment of exophthalmic goitre. In order to reduce the dangers and thereby increase the efficiency of surgical procedure in exophthalmic goitre, the following points are of practical importance:

1. Indication for Operation.—Surgical treatment is indicated in every case not permanently benefitted by rest, hygiene, diet and the use of a few harmless remedies, and also the serum treatment, except in cases of a temporary exacerbation of hyperthyroidism, and a hopeless condition of the circulation and nervous system.

2. Margin of Safety.—Plan to keep inside the danger line, even if a second operation is necessary to accomplish a cure.

3. Drainage.—Reduces the post-operative hyperthyroidism.

4. Traumatism.—Increases hyperthyroidism, thereby causing a marked difference after the operation.

5. Anesthesia.—Cocaine, one per cent, along the line of incision and along the course of the glands often sufficient; best, one-fourth gr. morphia and one-one hundredth gr. of atropia hypodermically, half an hour before the operation, and then patient thoroughly anesthetized with ether by the drop method, now with the head elevated at an angle of forty-five degrees, the operation can be completed without further administration of the anesthetic. The jaw must be held forward during the entire operation.

6. Avoid injuring the recurrent laryngeal nerve, the parathyroid gland, and the trachea; also important to remember to leave a portion of the gland.

7. Supply of liquid.—After the operation an abundant supply of liquid by any of the several methods is necessary in order to relieve the post-operative hyperthyroidism.

8. After-treatment.—Extremely important to lead a sedentary life after operation, and live on a diet comprised largely of milk, cooked vegetables and fruits.

9. Youthful patients.—In youthful patients, especially girls about the time of puberty or a little later, goitres cause symptoms of exophthalmic goitre. These will invariably recover under the appropriate medical treatment.

E. E. H., JR.

(Surgery, Gynecology and Obstetrics, January, 1912.)

A Study of Puerperal Fever.

Herbert Marion Stowe, Chicago, Ill.

This paper is a study of fifty cases of puerperal fever which died in a single hospital within twenty-nine months, but five cases of which offered any encouragement on entering.

They received an energetic stimulating treatment with strychnine, digitalin, alcohol, salines by rectum and hypodermoclysis, adrenalin, streptococcic serum and collargol.

As fundamentals of practice, the writer contends

1. All local infections require no local treatment, except in the presence of hemorrhage.

2. Interference converts a local to a general virulent condition.

3. Methods of diagnosing septicemia in the early stages are so uncertain that it is impossible before the disease has reached a stage not amenable to local treatment.

In treating septicemia, therefore, it follows that the local infection must have been intelligently treated, and *not* by instrumentation.

In septic abortions, if dilation is necessary, use packing and not instruments. If infection has spread beyond the uterus, it is best to leave the uterus alone, *whether empty or not*. The danger from retained membranes has been greatly overrated, and attempts to remove them are often attended with greater danger than their retention. Uterine irrigations are dangerous, and artificial drains are frowned upon. As to opening a pus-tube, this should not be done unless it is prolapsed into the cul-de-sac. In general exudative peritonitis, drainage by the cul-de-sac will relieve the peritoneum of much of its toxic irritation. Hysterectomy is indicated in only four conditions:

1. Uterine traumatism with, beginning infection.
2. Inflamed or gangrenous myomata.
3. Mortification of fetus in utero.

4. Purulent processes in the walls of the uterus, from which pyemia might originate.

The making of an early differential diagnosis, which is important, is difficult, and in making such diagnoses, the value of blood examinations is problematical, bacteriological examinations of the lochia show little, and we have to rely upon the clinical picture.

In treatment, serum therapy is of little use, the intravenous injection of bichloride of mercury has been tried with good results in some cases, any operation should be much hastened, and the general treatment is the most important.

In the discussion, Dr. C. S. Bacon emphasizes the rectal feeding as important, and advised as best the use of moderate amounts of alcohol for this purpose.

H. J. E.

Puerperal Infection.

Thomas J. Watkins, Chicago, Ill.

The writer makes as his cardinal points of treatment:

1. Raise the head of the bed.
2. Ice bag to abdomen.
3. Large amount of nutritious food.
4. Large amount of fluid.
5. Sun baths.
6. Relieve pain and give sleep.

The uterus should not be disturbed except for hemorrhage, retained placenta, or fetus, and should be cleaned out without ether. As to medicines, analgesics, soporifics, and laxatives are practically all that are used. Stimulants are not used as they interfere with the needed rest. Alcohol is thought to do more harm than good. Saline enemas are preferred to the continuous irrigation. He condemns operative procedures and intrauterine medication. He advises leaving pelvic exudates alone.

In the discussion, the speakers varied as to their ideas on the treatment of pelvic exudates, the closing speaker summing it up in that the treatment of these depended upon the general behavior of the case.

H. J. E.

(Surgery, Gynecology and Obstetrics, March, 1912.)

The Ultimate Results of Conservative Surgery of the Ovaries.

Edward Reynolds, M. D., Boston, Mass.

In summing up one hundred and ten cases treated in private practice, Dr. Reynolds believes that the puncturing of every cyst of the ovary, done in conjunction with other abdominal work, or with

plastic surgery, has been a great aid in getting results for the cure of dysmenorrhoea, nervous phenomena, often of some importance, and frequently of sterility. His method consists of the splitting of the ovary longitudinally so as to be able to palpate thoroughly each half for cysts not seen on the surface, to puncture each cyst so found, remove the cell wall, and suture the resulting wound. If the external surface of the ovary seems tough and leathery, he adds the scarification of this. In no case was the result productive of trouble, in many cases resulted in relief, and the author is thoroughly convinced of the efficacy of the measure.

H. S. E.

The Treatment of Ectopic Gestation.

Edward B. Cragin, M. D., New York, N. Y.

Dividing all cases according to whether or not the child is viable, and making this division arbitrarily at six months, he sub-divides the treatment as to whether the first class of cases is seen. 1. Prior to tubal abortion or rupture; 2. At the time of abortion or rupture; 3. After abortion or rupture. In the first class of cases, he without exception advises immediate operation; in the second the same, with the reservation that if operation is likely to kill the patient on the table, such operation may be postponed as long as the condition of the patient is gaining; in the third class, if seen only some time after the rupture, if there are no signs of sepsis, if the tube is surely empty, if the haematocoele is decreasing in size, operation is not essential. The author believes in removal of the affected tube at operation and the conservation of the opposite tube, if normal.

In advanced ectopic gestation, the author believes that an operation at eight and a half months for a living child. If the fetus is dead, he advises waiting for some weeks after its death before operating, so as to the more easily accomplish the removal of the placenta. This last named organ, in operations for a late living child is often left to separate spontaneously later, instead of being detached at time of operation.

H. J. E.

(American Journal of Diseases of Children, February, 1912.)

The Physical Evidence of the Thymus.

By Carl Bosch, M. D., and Adolph Rohn, M. D., Prague, Austria.

A series of experiments was conducted on one hundred and forty children before and after death to determine by percussion the area of dullness of the thymus, of which the findings in fourteen cases were

verified by autopsy and dissection of the gland. A special percussion instrument was devised for this purpose to give very light taps, and a muffled stethoscope was used for auscultatory percussion. Another method of outlining the gland was to place an unmuffled stethoscope or phonendoscope on the chest in the thymic area and stroke the adjacent skin with a small bristle brush. A distinct scraping sound was heard, except in those cases where the thymus extended beyond the sternum, where there was a dulling or absence of the scraping sound as soon as the brush entered the area of thymic dulness.

The gland grows until the age of puberty, the most intense growth being between the second and fifth years; after puberty, a general shrinkage sets in, while during exhausted periods at any age there is a marked reduction in the size of the gland. Extreme shrinkage or extirpation causes a checking of body growth and a condition in which the bones become more flexible and show a smaller callus after artificial fracture as compared with control fractures in normal individuals of the same age; electrical stimulation also shows a marked hyper-excitability.

R. B. M.

Recent Advances in Our Knowledge of Rachitis.

By Fritz B. Talbot, M. D., Boston, Massachusetts.

Etiology.—Most authors believe it a disturbance of calcium metabolism, either too little calcium in the food, or the normal calcium in the food is not absorbed in sufficient amounts, or it is absorbed and the bones are not able to assimilate it in a normal manner. A few men ascribe it to disturbances in the ductless glands, as the thymus, thyroid, parathyroids, adrenals, etc., and others claim it is an unknown disturbance of metabolism.

Pathology.—There is a calcium deficit in the bones; either primary, i. e., not enough calcium in the food; or, secondary, i. e., a decrease in the retention of calcium: that is, the new bone which forms as the child grows gets enough calcium, but instead of taking it from the food, takes it from the old bone which has already been formed, and so causes the old bone to become diseased. There is no anemia as a direct cause of the disease, but it may be a co-existent condition. Usually the red blood cells and the hemoglobin are increased, and there is no change in the leucocytes.

Treatment.—Phosphorus was originally recommended in 1883, and still holds first place in Germany, though Kissel in 1896, found that it has no effect on the skeletal system. Cod-liver oil is thought by most authors to increase the retention of calcium by the bone, and this action is intensified by the addition of phosphorus to the oil. This

increased retention starts in three to five days after the administration of the oil, and gradually diminishes until in two months the amount of retention is again normal. Olive oil is considered even more beneficial, and recently (1911) Schabad has demonstrated that calcium acetate cod-liver oil has the most favorable action on rachitis because it contains more calcium.

R. B. M.

Significance of Delayed Operation in Treatment of Ectopic Gestation.

By Emery Marvel, M. D., Atlantic City, New Jersey.

Hemorrhage and sepsis are the cardinal dangers of ectopic gestation. In order to safely combat them, it is necessary to remove the underlying cause, therefore the treatment is essentially surgical. Where the sac is unruptured, there is no justification for an opinion dissenting from prompt surgical intervention. In most cases, however, rupture has already taken place before a diagnosis is made, and there is some difference of opinion as to whether operation should be immediate or delayed. The author presents reports of twenty-four cases, of which one died without operation, six were delayed operations with the patient in bad condition and rapidly becoming worse, and sixteen operations with the patient in fair condition after absolute rest and the usual treatment for peritonitis. In all of these cases, the author is convinced that the operation was more difficult on account of the delay, and although all but the first (where no operation was performed) recovered, they presented dense adhesions, visceral distortion, and often inflammation in an active stage. He argues that hemorrhage is dangerous, and its control should not be delayed; that shock does not contraindicate operation; but that early positive control of bleeding opposes progressive shock depression; that early operation lessens the time of suffering and reduces the period of invalidism, and favors the prompt regain of health.

In conclusion, he asserts his belief that delayed operation imposes unjustifiable penalties upon the patient, and says that the significance of delayed operation is exhibited in: greater loss of blood; possible loss of life occasioned by hemorrhage; increased shock depression; recurrent hemorrhage producing worse condition than first; operation fraught with greater difficulties; more extensive pathology; increased discomforts, measured by time and intensity; crippled organs with deficient functions; protracted invalidism.

R. B. M.

The Treatment of Ectopic Pregnancy.

By Charles A. Stillwagen, M. D., Pittsburgh, Pennsylvania.

Contrary to the usual teaching that immediate operation is the

imperative procedure in any case where a diagnosis of ectopic gestation has been made, Stillwagen argues that operation may be safely deferred in the majority of cases. He believes that hemorrhage will not often recur if the patient be kept absolutely quiet, especially in grave cases, where the loss of blood decidedly increases the coagulability of the blood stream, favoring the formation of a firm clot. He also believes that sepsis is not apt to occur if it does not already exist at the time of rupture. His third and final argument is that delayed operation is safer than immediate operation, as in the latter the opening of the abdomen may add to the profound shock and anemia.

His method of treatment, illustrated with a series of eighteen cases (of which two were operated upon immediately after rupture and one before rupture) consists of absolute rest, external heat, morphine to secure quiet and combat shock, strychnine sulphate in small doses as a vaso-motor stimulant, physiologic salt solution slowly by rectum or subcutaneously. In this series of cases there were no deaths.

Conclusions:

1. Ectopic pregnancy at any stage is purely a surgical condition.
2. The time of operation, in terminated ectopic pregnancy, should be determined entirely by the patient's fitness to withstand surgical interference.
3. The time of operation should be decided by a competent surgeon, each individual case upon its merits.
4. Operation should be done at the earliest period of election.
5. To justify any given course of procedure, a low mortality rate must be shown.

R. B. M.

DEATH NOTICES.

IRVING E. KIMBALL, M. D., Medical School of Maine, Portland, Me., 1876; died at his home in Portland, Me., August 4, aged 61.

WILLIAM M. COWIE, M. D., McGill University, Medical Faculty, Montreal, Quebec, 1895. Died in Bangor, Me., August 4, aged 43.

MAURICE H. RICHARDSON, M. D., Harvard Medical School, Boston, Mass., 1877; died in Boston, Mass., July 31, 1912, aged 61.

Book Reviews.

Collected Papers by the Staff of St. Mary's Hospital. Mayo Clinic, Rochester, Minnesota.

W. B. SAUNDERS COMPANY.

The physicians of the country are coming to look forward to the regular publication of the papers from the Mayo Clinic. Among the few books of both immediate and lasting value in the surgeon's library these certainly will rank high. The papers are written by the Mayos themselves or by some member of the splendid staff at St. Mary's Hospital.

This last edition, published in June, 1912, includes all the papers read by members of the staff in 1911. The range of subject is of course wide, varying from careful studies of such rare conditions as mixed tumors of the parotid and diverticulitis to the much discussed ulcer and cancer of the stomach. Diseases of the alimentary canal and genito-urinary system occupy by far the larger part of the volume and there is a most extensive presentation of the surgical pathology of the prostate.

The book is made of especial value to the surgeon by many suggestions in operative technic as in the description of the kidney incision, and operation for ventral hernia. In one of the most interesting papers, Dr. Wm. Mayo describes his visits to some of the hospitals and surgical clinics in France.

The book is splendidly edited and the print and paper are excellent. Altogether we are most fortunate in having the opportunity to study in a single such volume the year's work from this, the greatest of surgical clinics in America if not the whole world. P. P. T.

An Essay on Hasheesh.

By Victor Robinson. Medical Review of Reviews, 206 Broadway, New York.

The author notes that "the modern descendant of Hypocrates draws his materia medica from the uttermost ends of the earth." The mineral, vegetable and animal kingdom have been tapped and yet, there is no drug which can relieve pain more than a brief period of time.

The author gives us a careful botanical study of the hemp plant but the exact chemical composition has not been determined. His historical tales go back to 500 B. C., tracing it through literature to the present time and closes his brief work with case reports of some of his friends who consented to submit to the experiment and finally his own sensations following a dose.

It is a very interesting little book and well worth the price.

F. Y. G.

County News.

HANCOCK.

The regular meeting of the Hancock County Medical Society was held on Wednesday, August 21st at the residence of Dr. Augustus Thorndike, Bar Harbor.

Dr. Benjamin T. Tilton of New York read an extremely interesting paper on "The Diagnosis of Perforation of Gastric and Duodenal Ulcer.

Dr. John C. Hemmeter of Baltimore in his paper on "Hyper-tonicity and Hypotonicity of the Vagus and Sympathetic Nerve as a Cause of Diseases of the Cardio-Vascular and Digestive Apparatus" gave some of the latest facts in research work relative to that line of study.

Dr. George W. Gay of Boston cited some very interesting experiences, from his forty years of practice, in a paper entitled "Opium in Senile Gangrene." It was shown that much can be done for the incurable chronic invalid to make life comfortable.

After the literary exercises, our host treated us to a very fine lunch.
G. A. NEAL, *Secretary*.

OXFORD.

The Oxford County Medical Society will hold its annual outing (Ladies' night), at Cape Cottage Casino, Portland, Thursday, September 5th.

Paper on "Eugenics" will be read by Dr. F. H. Gerrish of Portland.
G. H. HUTCHINS, *President*.

WASHINGTON.

The Washington County Medical Society held its regular meeting in August.

The following two papers were presented:

"The Competent Surgeon and the Etiology of Appendicitis," by A. Noel Smith, M. D., of Dover, N. H.

"The Medico-Surgical Transition Period" by H. F. Twitchell, M. D., of Portland.

H. B. MASON, *Secretary*.

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PERSONAL NEWS AND NOTES.

Dr. Wm. Bradford of Portland has recovered from his recent operation for appendicitis, and is able to resume his practice.

Among the Maine men attending the National Otological Society, held in Boston, last month, were Drs. Spalding, Holt, Smith, Allen, Fisher, Holt, Jr., of Portland, Beach of Augusta, and Austin of Waterville.

Dr. P. P. Lewis has returned to his home at Gorham after a short stay in Massachusetts.

Dr. A. P. Leighton, Jr., of Portland, has taken the Dr. Meserve house on Emery St., and will convert it into a Maternity Hospital, with accommodations for about eighteen patients.

Dr. Seth Gordon is enjoying the summer months at his summer home at Fryeburg where he was recently visited by about twenty-five of his Portland friends on the occasion of his eighty-second birthday. Dr. Gordon's health has been much improved since last summer.

Dr. Burrage of Portland is enjoying the summer at his new cottage near Bowery Beach, Cape Elizabeth.

Several of the older practitioners in Portland have taken up farming as an avocation and among those who have already splendid farms in operation are Drs. Alfred King, Henry Brock and Owen Smith. Dr. John Thompson who purchased a farm last year, is just completing thereon a new house which he intends to occupy during the summer months.

Dr. L. A. Derry of Portland has been spending the month of August at his summer home, Prout's Neck.

The Edward T. Mason Dispensary on India St., is fast nearing completion and promises to be a splendid addition to the clinical facilities of the Medical School. It will surely be in active operation by November 1st.

Drs. Baldwin and Jackson, who have just finished their internship at the Maine General Hospital, are intending to locate in Portland.

We regret to note that Dr. D. M. Stewart of South Paris is ill with typhoid fever and sincerely hope that he will make a speedy recovery.

Dr. C. W. Pillsbury of Saco returned home August 26th, after an absence of a week visiting in the eastern part of the State.

Dr. L. L. Powell of Saco has been passing the summer season at a cottage in Ocean Park, Old Orchard.

Dr. J. D. Cochrane of Saco has been a summer resident at Ferry Beach, where he has occupied his cottage, with his family.

Dr. John G. Potter, M. M. S., '08, of Houlton, and Mrs. Potter had an extended vacation trip this summer in various parts of New England. On their homeward journey, they had pleasant visits with friends in York and Cumberland Counties.

Word has been received recently that the deficiency bill passed by Congress on its last day contained the item for the \$43,880 for increased quarantine facilities for the port of Portland.

Dr. W. W. Dyson of Portland has returned from a two weeks' vacation in northern Maine.

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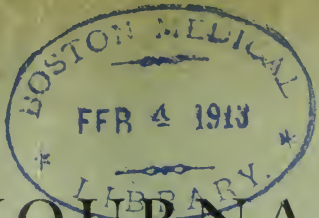
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No. 3

THE PREVENTION OF INSANITY.

DR. FREDERICK L. HILLS, EASTERN MAINE GENERAL HOSPITAL,
BANGOR.

Read before the Hancock Medical Society.

The last fifty years have seen a new development in medicine, the evolution of the science of hygiene or prevention of disease. More and more, in recent years, is the work of the physician having to do with prophylactic measures. More and more is he becoming a teacher, of the public, in avoidance of those things which will engender in the community the diseases which, until recently, it had been regarded as his chief function to cure, and while the healing art is making many and rapid strides in all branches of medicine, the important and valuable achievements of the art of prevention are gaining a wider recognition and observance.

The knowledge of the preventive measures against yellow fever has made possible the building of the Panama Canal. The knowledge of the prevention of tuberculosis is today resulting in a greater economic advantage to the world than can ever come from this greatest of engineering feats; and, when we consider that today the citizens of the United States are supporting at the public expense 150,000 insane persons, one for every 600 of the population whose insanity is to a large extent preventable, we get a little insight into the economic good that can result from a vigorous campaign for the prevention of

a scourge almost as productive of loss to the nation as is tuberculosis. There is a striking analogy in the development of thought in these two fields of medicine,—tuberculosis and insanity. Not many years ago, tuberculosis was generally looked upon as an incurable disease, both by the profession and by the laity. So also insanity. Then, within a few years a new day dawned for the tuberculous and the curability of his disease was heralded throughout the land. At about the same period, there was an awakening in the field of psychiatry leading to a better understanding of mental disease and a recognition of the curability of many of the insane. Finally, the clamor over the curability of tuberculosis was scarcely at its height when the cry went forth that prevention, rather than cure, offered the surest solution of the tuberculosis problem. Likewise today, we are beginning to hear much of the prevention of insanity rather than its cure as the most certain method of lessening its present burden on the community. Insanity even in its mildest forms, involves the greatest suffering that physicians have to meet, and it is undoubtedly true that there has been an increase in mental disease in recent years somewhat in excess of the growth of the population. This increase is less apparent in Maine than in States like New York where the population is dense and where the community is called upon to support a large number of alien insane who form a great part of the hospital commitments.

The first step necessary in the prevention of insanity is an adequate knowledge of its causes. In any case of alienation, we find the etiology is not simple, that not one but usually a number of varied factors are in different degrees active in the genesis of the disease. We have to deal with exaggeration of personal idiosyncrasies, with the peculiarities of the individual, character and temperament, with faults of heredity, development and training, all of which are as variously acted upon by intoxications, moral and physical traumata, etc., as are individual members of a community by the ordinary episodes of life. A true conception of the real etiology of a given case can often be obtained only by a painstaking study of the life history of the patient, his normal reaction to his environment, and of the effects upon him of both remote and recent events. "Mental diseases require for their development, a soil in an especially modified condition of long standing," says Jeffroy, and we find various predisposing causes playing an essential part in the modification of the soil. Chief among these are faults in inheritance, development and education. What can the physician do for him who has a faulty heredity to prevent the development of insanity? "It may be held as certain," says Clouston, "that bad environments, bad education, bad food, bad air, unsuitable occupations, mental shocks and stress, the

effects of disease, and unsuitable marriages will all bring out latent tendencies towards mental inefficiency or disease. Many of these could be avoided or counteracted if sufficient knowledge of hereditary risks had been acquired at early enough periods in the lives of the persons affected." He lays down the following general rules, by the application of which bad mental and nervous heredity may be counteracted: "Feed and strengthen the body by every possible means from childhood onward, do not over stimulate or over educate or over press the brain. Retard rather than stimulate the development of the higher functions; let them lie fallow, they will appear in time in a stronger and healthier form for this process. Watch most carefully the periods of puberty and adolescence, select occupations that are out-of-door, routine, unexciting, and generally wholesome. Observe carefully the moral, social and religious influences to which such an individual is subjected. Avoid as far as may be, the risk of bad examples. Do not be tempted by early acquirements, quickness and talent to think that there is, on that account, no risk of hereditary evils. Very much to the contrary is often the case." There are certain persons who, in childhood, are bright, studious, quick to learn, who seem quite normal until puberty, after which a gradual change comes over them, their interest lags, they become unsocial, develop an emotional irritability and find an increasing difficulty in keeping up with their work and studies. Upon this groundwork very frequently we see dementia præcox develop during the period of adolescence. This is a form of insanity making up about 20% of hospital commitments. It is essentially a developmental psychosis. Many of them have an heredity tainted by insanity, alcoholism, tuberculosis or a neurotic parentage. More have been peculiar from childhood, manifesting a precocious piety, moral instability, seclusiveness, eccentricities and sexual precocities, notably habits of masturbation. All of these things are expressions of an inherent, faulty makeup. This group seemingly offers small hope of success in the prevention of the development of a true psychosis by early recognition and the institution of some sort of educational control, but, even with such unpromising material, I am sanguine that much might be done could proper educational and correctional measures be carried out during the periods of puberty and early adolescence.

Laws prohibiting the marriage of defectives have been proposed and tried in the hope of limiting the hereditary and developmental insanity, but they are difficult of enforcement and thus far have been productive of but little good. Such marriages should, however, be discouraged and strongly advised against by the physician. Sterilization of defectives by vasectomy or salpingectomy undoubtedly offer

a safe and good method of preventing the propagation of their kind and is now legalized in several States, but the experiment is too new and the cases too few to have been productive of definite results and these methods are not very widely applicable. The segregation of defectives is another measure which, where practical, is probably the surest way of meeting the situation, but which involves an economic burden which the State is not ready or able to meet.

The question of the marriage of normal persons who are offspring of insane parents, or in whose family insanity is common, is difficult to answer satisfactorily. "The laws of hereditary transmission are yet imperfectly understood. In no individual can we be quite sure that the children will be insane, even if one or both parents have actually suffered from that disease, far less if there is a mere hereditary tendency thereto. The laws of atavism may bring it on a man who has had four generations of apparently sound ancestors; good environment and favorable conditions may antagonize bad heredity. Opposite temperaments in parents may result in healthy children. All these favorable facts we must honestly admit and bring before the prospective brides and bridegrooms who come to us for advice. Yet we must with equal honesty and sense of responsibility point out the awful prospect of increasing the direct and most hereditary disease which can affect mankind." (*Clouston.*)

Undoubtedly, many mental breakdowns are the result of faulty educational methods, of forcing nervous and backward children. Here is a field in which the physician and public school teacher can do much for mental hygiene. The teacher often recognizes the defective child, who is slow of comprehension, whose powers of application and concentration are defective, and who not only lags behind his class but impedes the progress of others. The school physician finds the nervous child, the poorly nourished child, and the child mentally dulled by adenoids, imperfect vision and the like. By proper remedial attention to these physical defects and by segregation of the mentally defective in special schools or classes much good can be accomplished. Training in such schools should have to do not only with pedagogics but with self-control and self-mastery of vicious tendencies, in the curbing of the temper, the strengthening of the will, practice self-denial and should include instruction in temperance and sexual hygiene. Such schools have been inaugurated in many of the larger cities and even where a separate school is not economically feasible, it is quite possible to organize classes with a teacher competent to give such instruction.

In February, 1911, Dr. Llewellyn F. Barker read a paper before the Public Health Conference in Baltimore, entitled "Principles of

Mental Hygiene, applied to the management of children predisposed to nervousness." This paper has been published in pamphlet form and I commend it to you as a tract which should be read by every parent or by whoever has to do with the management of children.

Turning now to some of the more tangible causes of insanity than heredity, faulty development and education. First, in importance is alcohol. While in most States alcohol is the direct cause of insanity in about 25% of all cases, and the contributing cause in as many more of the male admissions, even in Maine, where a prohibitory law has been in the statute books since 1851, we find alcoholism a cause of first importance. During the last nine years, about 11% of the men admitted to the two insane hospitals in Maine were suffering from alcoholic insanities. The percentage of alcoholic cases coming to Bangor is considerably higher than at Augusta, the statistics showing 8% in Augusta, and 14% in Bangor. Not only do we get insanity from direct effects of alcoholic indulgences, but also to a very large extent through its secondary effects.

The congenitally defective children of alcoholic parents, lowering of the vitality and resistance of its devotees, rendering them more susceptible to infections, and the poverty and mental and physical distress that follows in its wake. In this and many other ways is alcohol a great factor in the causation of insanity. That we and our children may have good mental health, total abstinence from all alcoholic drinks must be enjoined upon all. The low rate of alcoholic insanity in Maine is doubtless due, in part, to the fact that we have a small foreign population and in part to the working of the prohibitory law. The local prevalence of the alcoholic insanities in certain sections is undoubtedly due to the failure of that law where the public sentiment is not for its enforcement. But, that it is a factor for the prevention of insanity when properly enforced, cannot be gainsaid.

Hand in hand with alcohol in the etiology of insanity stands syphilis. In fact, if syphilis is the cause of paresis, it is today a greater cause of insanity in Maine than is alcohol. Last year, 41 out of 159 patients admitted to the Eastern Maine Insane Hospital were suffering from paresis. 31 out of 198 admitted to the Maine Insane Hospital were suffering from paresis or syphilitic brain disease. That syphilis or syphilis combined with alcohol is the prime factor in the production of paresis is, I think, generally recognized. Here is another preventable psychosis. Here we see the importance of an energetic campaign for the education of the public as to the dangers of venereal disease, a campaign for sexual hygiene and morality. The public should be taught that the contracting of this disease may not only result in untold physical ills, but in the production of an

incurable insanity not only for him who contracts the disease, but for his innocent wife and for his children, if he is so unfortunate as to have any, unfortunate because it is almost inevitable that he will see the result of his sin transmitted to them. Alcohol and syphilis were the causes of 29% of the insanities in Eastern Maine last year,—insanity preventable by total abstinence from alcohol and by sexual morality. I deem it to be the duty of the medical profession not only to treat these diseases energetically, but to teach the public of their dangers, their avoidance and their prevention and particularly to teach these things to the younger generation. The physician has also a duty in the prevention of drug psychosis, especially those caused by the use of morphine and cocaine, which are increasing in frequency, and which are often regrettably brought about by failure on the part of the physician to put proper safeguards about the use of these drugs. There is a laxity, also, in the dispensing of these drugs at the pharmacies, with or without a physician's prescription, and a disregard of the laws which cannot be too severely condemned. There is law enough regulating the sale of these drugs, and the medical profession can do much by promoting and demanding their strict enforcement on the part of the druggists.

Another group of mental diseases we find to follow certain of the acute infections,—typhoid fever, measles, influenza, rheumatism, puerperal infections, etc. While these post-infective psychoses are usually curable, we sometimes see a permanent insanity develop especially in those persons predisposed by heredity. Every step taken by the medical profession in the prophylaxis of infectious disease, every advance in their laboratory investigations and in their control by serum-therapy is a step toward the prevention of insanity. Krapelin attaches much significance to auto-intoxication as a cause of various psychoses, some forms of manic depressive insanity and dementia præcox. Undoubtedly faulty food and body metabolism result in the production of chemical substances poisonous to the nervous tissues, but we are still ignorant as to the true nature of these poisons, and the whole subject of auto-intoxication is very much in the air. We do know that by proper dietary regulation and attention to the manner of living and to general hygiene, we can correct many errors of eating and of living which lead to the production of arterial degenerations, and other faults of the body chemistry predisposing to mental and nervous diseases.

Through surgery, we can correct many conditions leading to insanity; such as, the results of head trauma, tumors of the brain, cancers and abnormal conditions of the genito-urinary system. I should, however, say a word of caution relative to the resort to hysterectomy

and ovariectomy with the hope of relieving actual neuroses or insanities. It has been my experience that when these operations were done in the presence of severe nervous or mental symptoms, the latter have been aggravated rather than relieved by these procedures.

So far, we have dealt only with the physical causes of insanity. Not infrequently we meet with cases where the causes are wholly or in part mental. Sudden emotional shock, prolonged mental strain, overwork, worries occasioned by family troubles or domestic difficulties, sexual misadventures, abnormal modes of life, loss of property, changes of environment, all of these things lead to mental depression, insomnia, nervous irritability and ultimately to insanity.

Prolonged loss of sleep occasioned by many of these factors not only reacts on the emotions, but results in a certain amount of toxemia of the nervous tissues. Such etiological factors were presented by 13% of the cases admitted to the Bangor Hospital last year and over 50% of those whose insanity was built on such a foundation, gave a history of hereditary predisposition. Doubtless, many of these things are inevitable incidents of modern life, but some, at least, can be prevented by reducing the pressure of activity under which the race is run. Men today, in their strife for "the one thing more," for the unattainable, lose sight of the danger signals, and by overwork and by over stimulation, invite a Titanic disaster to their nervous systems. It is our duty as physicians, to keep a sharp lookout for the dangers ahead, and if possible, give adequate warning of the impending disaster.

"The fundamental conditions of a sound brain" says Forel, "are a normal hereditary disposition, the avoidance of chronic poisoning (alcohol and syphilis), constant exercise, good nourishment and necessary sleep. These foundations of nervous hygiene should not be disturbed, a few short transgressions may be borne if one is good and strong, but if anybody breaks one of these rules continually, he pays for it with, at least, a part of his nervous health. When we realize that during the last year 37% of those admitted to the Eastern Maine Insane Hospital were suffering from insanities due to preventable causes, we can appreciate the wisdom of the campaign for the prevention of insanity. Such campaign should be conducted along lines similar to those employed in the fight against tuberculosis. There has recently been organized in New York State, a National Committee for Mental Hygiene, the objects of which are: To work for the protection of the mental health of the public; to help raise the standards of care for those threatened with mental disorders or actually ill; to promote the study of mental disorders in all their forms and relations and to disseminate knowledge concerning their

causes, treatment and prevention: to obtain from every source reliable data regarding conditions and methods of dealing with mental disorders; to enlist the aid of the Federal Government so far as may seem desirable; to co-ordinate existing agencies and help organize in each State in the Union an allied, but independent Society for Mental Hygiene, similar to the existing Connecticut Society for Mental Hygiene.

Surely, there is a field in Maine for work along these lines. Of the making of new societies, there is no end, and I am quite confident that existing agencies might be used to advantage in such a campaign in this State. The State Board of Health through its bulletins on preventive medicine can disseminate information as to the prevalence, causes, and prevention of insanity. The State hospitals for the insane should make such provision for the establishment of out-patient departments or dispensaries for free treatment of patients suffering from insipient mental disease. Each hospital should have a social service worker, who would visit the houses of the patients discharged from the hospital, advise them, study their environment and collect information bearing upon the local causes of insanity, heredity, etc.

There should be enacted proper voluntary admission laws allowing the reception into the hospital of early or borderline cases as voluntary patients, without the publicity and delays of a formal commitment.

The medical profession, as a whole, should take more interest in mental medicine, learn more of the early phases of insanity and should enlighten the public as to the importance of its early treatment and of the fact that the modern hospital for the insane is as much a hospital for the sick as is a general hospital and that there is no more disgrace attending treatment in its wards than there is in treatment in a hospital for tuberculosis, or cancer, or appendicitis. When the causes of insanity are as widely known as are causes of other diseases, when the public has lost its superstitious dread of the mentally ill; when mental diseases are given their proper place in the medical curriculum, their study made compulsory and not elective, we may then hope for a saner understanding of insanity. In the meantime, let us do our part in our respective fields to enlighten the public and to further the cause of mental hygiene.

THE NEED OF CORRECTING FLAT FEET.

M. S. YOUNG, M. D., OAK BAY, N. B.

Read before the Washington County Medical Society.

A few years ago the mincing gait of strained foot and the stumping of flat feet were rarely seen; today the percentage of those walking with an abnormal deviation of one or both feet, characteristic of these troubles is very large, especially among young women. The human being was intended to walk with the outer edge of his foot flat against the ground, heel and ball at the same height, and among those who so dress their feet, this trouble is rarely seen. The American aborigine is a good example of this. Raising the heel of our footwear, throws more weight upon the arch and a certain amount of eversion, which we call normal, ensues. Why—I do not pretend to say, but the moccasined Indian and the barefoot boy uphold my contention. The scaphoid forms the keybone of the pedal arch, and to this and the internal cuneiform, are attached some of the leg muscles. In relation to the bony structure of the arch, the plantar fascia may be regarded as the bowstring to the bow whose arch can only be flattened at the expense of stretching the bowstring, and when the natural tension of this fascia is increased, we have arrived at the beginning of a process that may properly be termed strained foot. Let the process be continued and we pass through the various stages of falling arch, and arrive at complete flatness, with its inseparable eversion sometimes to an angle of 90 degrees.

This flattening is really a partial dislocation, and every step now taken is accompanied by an attempt at articulation of surfaces which were never intended to be articulated in just that way. This grinding of non-fitting articular surfaces results occasionally in an arthritis, but why it does not more frequently so result, I am at a loss to understand.

When flatness has been reached, the person walks with greatly everted feet and with a disproportionate amount of weight borne upon the inner plantar surface.

Consider the muscular attachments at the arch, and the effect of any long continued strain upon these muscles. If you wish to learn how it feels, hyper-extend the forearm for half an hour and note the effect. We sometimes diagnose this condition as muscular rheumatism, but when we do, we have another guess coming.

As the arch begins to flatten, we may have changing relations in the articulations at the ankle, knee and hip, though this condition may have developed so slowly, as to give little trouble to the patient, but,

the more marked the flattening, the greater is the change in the articular relations at the above named joints.

The rigid foot is the final stage. Fortunately this is of infrequent occurrence, and yet some cases are to be found in every community. This condition I think, always results from the arthritis already mentioned.

SYMPTOMS—Strangely enough, rarely will complaint be made of the feet. Aching of the muscles of the calf, thigh, hip, or discomfort at the ankle, knee or hip joints cause the physician to be consulted. While the pathological condition is confined to strained foot, the symptoms will be entirely muscular, and referable to the calf usually, sometimes to hip and thigh muscles, because the muscular system above is involved.

When changed bony relations occur in the foot, associated as they frequently are with similar changed relations at the knee, ankle and hip, the patient describes joint symptoms, and I have made the mistake calling the condition, chronic rheumatism; perhaps you have not. One will always be safe in calling it "Chronic" for it surely will remain obstinate under any so-called rheumatic treatment and it is frequently difficult to convince a patient that the trouble originates in the foot. I recall one patient who complained only of pain in the hip while walking and made worse by stooping, and was practically a cripple on this account. After excluding possible acute joint trouble, by the ordinary methods of diagnosis, I examined the feet and found quite a bit of flattening, but nothing I could say convinced her that the trouble could be elsewhere than the hip. As a favor she permitted me to strap up the arch carrying the strips from outer dorsum under arch, across in front of ankle, to median line posteriorly. In two days she reported saying she was much relieved, but was certain her feet had no connection with the trouble. I removed the plaster, the arch immediately dropped, while the return of pain in the hip was almost instantaneous.

Pain in knee, especially on inner side, which may or not be accompanied by tenderness is almost a constant symptom in the advanced case, and, not infrequently, pain in the hip, the latter sometimes simulating sciatica.

Localized neuralgias I have seen disappear after reposition of the arch, but I am not prepared to say what relation one bore to the other.

The gait is characteristic, after one has given the subject just a little study, you can not avoid, if you wish, diagnosing these cases, even in their incipency, as you walk along the street.

First, the pedal eversion usually just in the right foot, next an unnatural prominence of the tubercle of the scaphoid showing even through the boot, then the mincing gait, further eversion, and finally the finished product, with the stumping gait.

The initial symptoms are now seen most frequently among the younger girls, walking upon the fashionable high heels, and in these cases you will find an unnatural tension of the plantar fascia, if you place the fingers under the arch of the bared foot, and have the weight borne on that extremity.

Unless these conditions are corrected, the next stage soon arrives and we are consulted on account of those muscular symptoms to which I have already referred. This is the time when the family physician can be of more service than at any other period in this trouble, and I know no pathological condition so important that we so grossly neglect.

"Go down to the shoe store and have a pair of arches fitted" is a bit of advice we have all given, but I really think it is on par with the attempt to make one pair of crutches fit all the convalescing fractures in the community and because nearly all patients are rendered more comfortable by any kind of a support, we conclude we have done our full duty when we have delegated to the shoe store the task of bringing about the gradual reposition of dislocated bones. The ready-to-wear arches are made to fit the boot, and have no relation to the individual amount of deformity this particular patient possesses, and yet, it is this particular static deformity we desire to correct. We cannot expect to bring about in these severe forms, or even in the moderately severe type, a complete reposition at one time. It may take nearly as long to reduce the dislocation as to produce it, though frequently rapid reposition is possible. Possibly surgery may be able to do more, but up to date it has not so been demonstrated.

A campaign of education against the present boot monstrosities generally worn is in order, and to a limited extent it will prove successful, for a small number of persons will be influenced. In the strained foot type, frequently the resumption of proper foot wear, together with suitable muscular exercise, will accomplish all that is required.

Beyond the stage of strained foot, artificial support is indicated, but to be efficient, it must be fitted to the foot in such a way as to give the greatest amount of lift to the arch consistent with the comfort of the wearer. I do not think this can be done in the shoe store, and neither can it be done by fitting the support to a cast of the foot in a hap-hazard way, in the physician's office. It is an important surgical procedure and should be so regarded. At this point trimming

the cast is largely a matter of judgment, but if he will begin the trimming at the scaphoid, thus raising the keybone of the arch, as much as seems indicated, and make further trimming secondary to this, he will not be very far out of the way. The guides to indicate the amount of trimming are the amount of flatness, and most important the mobility of the foot. If you attempt to raise a foot complicated with arthritic exudates, kindly remember before you begin that your troubles are also beginning, and you will have no difficulty in recognizing them.

Over the cast now trimmed, may be fitted a german silver or annealed steel plate extending from the middle of the os calcis to the great toe joint. It is in many instances better to cover with thin leather, as a surety against the effect of rust, as well as a guide to assist in keeping the plate in its position. From time to time the arch of the plate may be raised until the maximum of correction is reached. From the time plates are adopted, daily exercises to prevent atrophy of the muscles must be carried out, otherwise no hope of permanent improvement may be looked for. Do not ask the patient to wear this longer each day than is comfortable, until accustomed to its pressure, which will be, if the cast has been properly trimmed, rarely exceeding a week.

In the rigid foot as well as that complicated by arthritic thickening, absorption and mobility must be brought about before any attempt at lifting the arch is made, and for this purpose I know nothing of greater service than the hot air apparatus. I have used one of the Betz Machines for eight years and it is now doing good work. For those who have electric light available, I have seen a very good substitute in an asbestos lined plain box, containing a half dozen or more ordinary electric bulbs. The baking together with counter-irritation will accomplish wonders.

The difference between the cast as made and when trimmed, represents the amount of lifting, which in the opinion of the physician that particular arch will at that time bear, and subsequent elevation should be made from time to time and as early as the increased mobility of the foot will permit.

Perhaps the most satisfactory exercise for preventing atrophy is rising upon the toes.

Perhaps you have noticed that a majority of persons with flat feet have varicose veins, but whether this is merely a coincidence or cause and effect, I am not prepared to say. It would however, be interesting to make enough of observations to determine that point although we are not suffering for further reasons why we should bring about correction of the condition under consideration. If this

short paper will be the means of causing just one person to give more attention to the diagnosis of the most easily diagnosed of all surgical troubles, if it calls attention to a probable cause of many obscure muscular and articular discomforts, if it induces just one to look after the treatment, instead of referring them to the shoe store clerk, I shall feel satisfied.

REMINISCENCES.

ELMER SMALL, M. D., BELFAST, ME.

Read before the Waldo County Medical Society, March 1, 1912.

In this paper I propose to deal largely in reminiscences. I think you will grant me your indulgence, when I tell you that, at the present time, there are but two practitioners in the county who have been in the business longer than myself. In the forty two years I have devoted to the practice of medicine, I have attended at least 1,500 cases of full term confinement, and it is to this class of cases that I propose to call your attention, more particularly to those forms of puerperal morbidity due to infection, which have come under my observation. Each practitioner, undoubtedly, has an experience peculiar to himself. While I have met with many of the conditions and accidents laid down in works on obstetrics, there are some which one supposes would be met with commonly, that I have never seen. I have never seen a case of placenta previa, nor met with a contracted or deformed pelvis—or an hour-glass contraction of the uterus. I have never had a case of fatal flooding, and never had to deal with but three serious cases of that nature. I have seen but one Cæsarian section. I have had one case of complete inversion of the uterus, which I was fortunate enough to recognize and replace at once. I have officiated at the birth of one set of triplets—all of which are living at the age of 21—and at the birth of from 12 to 18 sets of twins. I did not have time to go back over my records to make an accurate count. I have met with two cases of spina bifida, one case of hare lip, three cases of club foot, one acephalic child, two cases of auencephalism, one hydrocephalic case, with not above one-half dozen cases of phlegmasia and none of a serious type, four cases of suppurative mastitis, two of which occurred shortly after confinement and two from 6 to 9 months after confinement, three cases of puerperal insanity, one developing during the later months

of gestation and lasting for three months after delivery and two occurring two to three weeks after confinement, one of which died, but was complicated with syphilis of a number of years standing. I recall ten cases of eclampsia with four deaths, one case of pulmonary tuberculosis in which death followed within a week after confinement, one case of sudden death from thrombosis, one death a few days after confinement which I was at a loss to account for, and one death one week after confinement which was characterized by suppression of urine, and vomiting profusely of large quantities of fluid, colored with bile and accompanied with headache and subnormal temperature. This case I regarded as uræmic. Seven cases of puerperal infection of severe type with four deaths, 13 in all. It will thus be seen that infection has claimed a much larger percentage of victims among my cases than any other cause and I think my experience will coincide with that of the majority of practitioners who have followed the business for many years. Accepting the infection theory as the cause of our greatest source of trouble during the puerperium and considering the environment of the greater number of women during the lying-in period, it is wonderful that there are not more such cases met with, and especially that there *were not* more cases during the earlier years of service of our older practitioners, when our ideas of asepsis were in so primitive a state that it was not considered criminal among good practitioners to carry a catheter ready for use in one hat-band or to strap a knife on one's boot-leg before using it in operating, as I saw once a number of years ago. I think no one at the present day doubts that our most serious conditions in women after child birth, are due to presence of micro-organisms introduced into the system from without; from putrefactive changes, or sapsemia, inducing ptomaine poisoning; from mixed infection; or that the nature of the infection differs at all from sepsis found in women not pregnant, in men, in new born children, or in surgical cases, where conditions favor the introduction of septic matter. Infection may be conveyed by the physician, or nurse; by contact with some infected dressing; through unsanitary surroundings; through the existence of micro-organisms, upon or within the genitalia before confinement—and that, to this latter condition, only, can be ascribed cases of so-called auto-infection which may be reckoned with as a factor where physicians and nurses have taken all due precaution so far as they personally are concerned. The puerperal woman differs from the child or the man, only by being more susceptible to the introduction of the poison, by presenting more points of vulnerability. Edgar states that "It is generally conceded that the uterus and its contents before delivery are sterile. Excep-

tions are found in cases of endometritis and putrefaction of a dead foetus." After delivery there is, from above downward, the exposed placental site, with its torn venous sinuses, possible lacerations of the cervix, and more or less abrasions and lacerations of the mucous surface of the vagina, vulva and of the perineum, all of which surfaces present admirable foci for infection from without. Within the uterine cavity, especially if bits of placenta or membranous shreds and other debris are present. These together with the lochial discharge furnish an ideal culture medium for the development of bacterial life.

Here I will pause to say that in my experience with the dead foetus, however badly decomposed, and with whatever changes there is a case of serious infection develop—in fact that class of cases has a case of serious infection develop—in fact that class of cases have happened to do exceptionally well in the way of prompt recovery. But I can conceive of serious results obtaining from these conditions. By infection of these abrasions or lacerations, local ulcers are frequently formed, with the production of false membrane of a diphtheretic type. Even then there is a decided tendency to recovery, as the formation of a defensive barrier of leucocytes tends to prevent penetration to deeper structures and the membrane is exfoliated or destroyed by sapsophytic changes.

If these ulcers are not found upon the cervix there is small likelihood of intra-uterine invasion. I have observed that there are but few cases that run no elevation of temperature after confinement—and that on the contrary a temperature of one hundred and one or two degrees or three degrees even, if continued for a week or longer is not incompatible with good recovery. I know of no other way of accounting for this condition than to class them as cases of mild infection where the resistant powers of nature with the formation of the leucocytic wall—or by the development of antitoxines or by some other means protect the system at large from extension of the disease. If infection reaches the endometrium, it may extend through the tubes to the ovary and through the lymphatics; from the uterine cavity to the parametrium and peritoneum, or through the veins with resulting pyaemia. When the powers of nature do not prevail and infection is not checked it is more or less rapidly progressive, but, like a fire, if discovered in an early stage before it has gotten beyond *reach* and consequently beyond control, in many instances, it may be arrested and prompt recovery take place, where delay would be disastrous. Here I will come to the practical point I wish to make in this paper by reporting my eight cases, and from this report you may draw your own deductions.

CASE 1. Occurred about twenty-five years ago. The patient, Mrs. S. Multipara. Age 35. Attended by a mid-wife, delivery normal. Was called on the fourth day after confinement, found her suffering from general peritonitis which had been preceded by a heavy chill. Abdomen swollen; tender over uterus, lochia suppressed. Decubitus dorsal, with limbs drawn up. Pulse and temperature high but cannot give exact figures. Died on sixth day—undoubtedly streptococcic or mixed infection.

CASE 2. April 5, 1899. Patient primipara. Age about twenty-four. Forceps delivery. April 8, heavy chill followed by fever. Temperature one hundred and five degrees. Lochia suppressed. Abdominal tenderness, severe headache, muttering delirium. Skin dry. Died April 12th. I learned that her mother died of puerperal fever.

CASE 3. February 21, 1904. Mrs. N. Primipara. Age twenty-eight. Protracted labor. Forceps delivery. Condition satisfactory until February 24th. Heavy chill on night of 24th. Was called on morning of 25th. Temperature one hundred and six degrees, pulse rapid. Abdomen distended and tender. Foul odor to lochial discharge. Used frequent douches of bichloride. Large doses of quina. Calomel triturates followed by saline. Next day used anti-streptococcic serum. No benefit. Grew rapidly worse. Died February 27th. Diagnosis, streptococcic infection.

CASE 4. Mrs. W. Age, 18. Primipara. Confined March 8, 1904. Easy and quick delivery. March 11, heavy chill. Tarry and foetal discharge per vagina. Swelling and tenderness. Delirium. Great prostration. Treatment much same as preceding case. Died March 13th. I afterward learned that this woman was confined in a room and on a feather bed used by a man who died from abscess about the rectum or some form of suppurating disease from which he was confined to his bed a number of weeks.

CASE 5. August 25, 1907. Mrs. T. Age about twenty-five. Primipara. Arrived just as delivery was taking place. Placenter in twenty minutes. Patient in first-class condition. Comfortable and nothing unusual the next day. Visited her the morning of the 28th, when her husband met me, saying, I am glad you are here for my wife has had a severe chill and is delirious. Upon entering the room, I found her delirious, pulse one hundred and thirty, temperature one hundred and six and five-tenths degrees. Face scarlet. Remembering my experience with the four preceding cases, I recognized the fact that this apparently was the most serious of all, and that something must be done and that speedily or my past experience would be repeated. Fortunately I had some creolin in my bag and a uterine irrigator, which

I inserted into the uterus and thoroughly washed it out with a creolin solution, one-half drachm to the quart. After two hours, temperature had fallen to one hundred and three degrees. Upon returning at 4 P. M., I found her temperature one hundred and six. I again inserted the irrigator and douched her with normal salt solution, and followed it before removing the irrigator, with four ounces of absolute alcohol. Left calomel triturations to be followed with a saline. The morning of 29th, I found her free from delirium with a temperature of one hundred and two degrees. Repeated the normal salt and alcohol douche. She made a rapid and satisfactory recovery. In sixteen months, I attended her again in confinement which was in every way normal.

CASE 6. October 21, 1910. After a protracted labor, I delivered Mrs. M., age thirty-five, primipara, by version, which took something over an hour to accomplish—it being the hardest experience of the kind I ever experienced. There was an extensive laceration of the perineum. During the night of October 25, she experienced a most pronounced chill and on the morning of the 26th, I found her with the characteristic temperature of infection, one hundred and six degrees strong. I used the normal salt and alcohol treatment with some reduction of temperature following. The next morning the temperature was again one hundred and six degrees. Repeated the douches. It did not go above one hundred and four degrees after the second treatment but remained at about that figure for two days afterward. I think I gave her four alcohol douches in all. There was a great flow of pus and much tenderness of abdomen. In three weeks, she was about the house.

CASE 7. May 18, 1911. Mrs. J., age 16. Primipara. This patient a few days before delivery was taken with uterine hemorrhage, without pain. Finding that I could not control it, I delivered her by version of one child, finding another presenting foot removed that also. Uterus contracted fairly well. On the third day, I found her with a temperature of one hundred and three degrees. In spite of my efforts for relief it remained at that figure or a trifle higher until the night of May 25th. There was some odor to the discharges and I had used vaginal douches of bichloride daily up to that time, together with quinine as a febrifuge and tonic. Near midnight on the 25th, I was called and found she had had the usual chill, followed by the usual high temperature, and was somewhat wandering in mind. Her father stated that her mother had died under similar conditions. I used a normal salt and absolute alcohol intrauterine douche, and repeated the same the next day with prompt reduction of temperature. After treatment was of a tonic and supporting nature. I think she was out of bed in four weeks. Diagnosis, endometritis and mixed infection.

CASE 8. Mrs. M., age twenty-eight. Primipara, August 6, 1911. Natural delivery after ten hours labor. Perineum lacerated. Sutured at once. Pus appeared in lochial discharges and perineum did not heal. On August 11th, I was called on account of a heavy chill and found temperature one hundred and six and five-tenths degrees. In this case, abdomen was swollen and very tender, especially in left ilias region and painful. Intense headache and some mental confusion. Resorted to the creolin and alcohol treatment and repeated it daily for four days. Temperature would fall to one hundred and three degrees shortly after a douche but would reach one hundred and four degrees the next day until the fourth douche was used. She had rather a lingering recovery.

To sum up the situation, I lost four cases in succession and the three following in succession lived. The initial symptoms in the latter cases were as grave, if not more so, than in the first series. I believe the treatment saved them. Of course the infection could not have advanced beyond the uterine cavity in these cases. Had it done so the treatment, being of a local nature, could not have reached it. I am led to believe that by seizing the "psychological moment" at the commencement of the infection, a larger percentage of cases can be saved which would invariably be fatal, if left to nature. My theory is that alcohol acts not only as a germicide but by combination with the diseased tissue forms an artificial barrier to the further progress of infection similar in effect to the leucocytis which nature provides in the milder cases. The nearest approach to this treatment which I can find is in Edgar's Practice of Obstetrics, in which he states, that in cases of endometritis, "Perhaps a fifty per cent solution of alcohol is worth while and may be repeated in twelve hours if no benefit is observed." So far as my experience goes, the full strength alcohol causes no particular inconvenience, and is attended with no danger if used with an irrigator of proper construction. It must be used early to do any good. On the whole, puerperal infection is a preventable disease—largely—if not entirely so. The old adage, "An ounce of prevention is worth a pound of cure," supercedes all other considerations in obstetrical practice. If the genital tract is kept sterile, infection is an impossibility.

SURGICAL SUGGESTIONS.

A testicular enlargement, even though of rapid development, not associated with evident urethritis, not very tender and not following instrumentation, should never be dismissed as due to "a strain." It is in all probability neoplastic, luetic or tuberculous. If the Wasserman reaction is negative, the testicle should be promptly examined by operation!—*American Journal of Surgery*.

Necrology.



HENRY MARTIN BLAKE.

Dr Henry Martin Blake, for many years an honored member of our Association and a prominent citizen of Monmouth, was a son of Epaphras Kibby Blake of Monmouth, who descended from Phineas Blake, one of the founders of that town. This ancestor it was, who being an intimate friend and connected by marriage with General Henry Dearborn of the United States army, and the hero of the battle of Monmouth during the Revolution, named the new town in Maine in honor of that celebrated victory.

Henry Martin Blake was born in Monmouth, November 29, 1836, studied in Monmouth Academy and at Kent's Hill, and was graduated from Wesleyan University about 1865. He taught school for a while, became principal of Limerick Academy and then of Monroe Academy in Monroe, Wisconsin. During vacations he studied medicine, and ob-

tained his degree in medicine at Bellevue Hospital Medical School in 1866. He settled for practice, first at Readfield not far from his native village, and after six years there, he removed to Monmouth where he practiced the entire remainder of his life. He soon obtained and for years maintained a large and successful country practice, became connected with the American, State and County Medical Societies, and was long known as a very capable and skillful practitioner, and particularly clever in diseases of the lungs.

As a citizen, Dr. Blake was one of the foremost, and as a physician, he earned an enviable reputation for gentleness combined with firmness, courtesy and faithfulness. He died suddenly, Sunday, April 7, 1912, from pneumonia, when a few days before apparently as active as ever, after more than forty years of practice.

Dr. Blake married Miss Frances Pierce of Monmouth who died before him and left two children.

J. A. S.

IRVING ELLIS KIMBALL.

Dr. Irving Ellis Kimball, one of the earliest specialists in diseases of the naso-pharynx, in Maine, died Sunday, August 4, 1912, after many months of suffering from a complication of diseases of the heart and kidneys. He was the eldest son of Ebenezer Palken Kimball, and Tryphosa Fessenden (Nye) Kimball his wife, of Clinton, Maine, and was born in that town, September 2, 1852. He studied at Bucksport Academy and I think that he entered some college. He did not however, finish any college course but studied medicine at the Medical School of Maine, where he was graduated in 1876. Soon afterwards he settled in Wiscasset as a country practitioner of medicine and married Miss Frances Mary Tucker, belonging to one of the best and very well known families in Maine. When she died about two years later, Dr. Kimball decided to remove to a larger field of practice, and came to Portland about 1879.

About this time, specialties were growing into favor with physicians and people alike, and Dr. Kimball decided to devote himself to the diseases of the naso-pharynx, with especial attention to those of the lungs involving tuberculosis. With this in view, he studied at Harvard, and later on made a voyage to Europe, where in Vienna, especially, he studied abundantly concerning the operative and medical treatment of the diseases in which he was interested.

Dr. Kimball's medical reputation and fortune were built upon two medical papers which he read before this association, one in 1891

on "Adenoids," and another in 1896, on "Nasal Suppurations." From the day on which he read his brief paper on adenoids, he became known all over Maine as the first physician in the State who had ever written concerning this very important affection in children, and people flocked to him from all over the State. How many operations for adenoids he performed, or how many times he operated for removal of the tonsils or for obstructions of the nasal passages is not known, but they must have numbered enormously. He also obtained a high reputation as a diagnostician of early tuberculosis. People liked his personality, he easily attracted practice, people followed for years his least suggestion for continued visits, and he held on to his patients without any effort on his part except to encourage them in their faith that he could relieve, even if he could not cure, their many manifestations of diseases of the naso-pharynx. His manners were suave, attractive and winning, and accounted largely for his very successful career as a specialist.

Dr. Kimball belonged to many medical societies, the names of which hardly need repeating with their extensive terminology, the chief of them, however, being devoted to the diseases in which he specialized. His communications before them were, however, very rare if any. He belonged, additionally, to many private medical and social societies in Portland. He served for a short time on the surgical staffs of the Maine General and of the Eye and Ear Infirmary but after a while retired from those positions, believing that he could do better work in private than in hospital practice.

Soon after removing to Portland, Dr. Kimball married Miss Susan Jackson Rollins of Portland, who survives him, without issue. Mature deliberation justifies me in saying that the present generation of medical practitioners in Maine is unlikely to witness any such successful career in any medical specialty as that which attaches itself to the memory of the career of Dr. Irving Ellis Kimball.

J. A. S.

SURGICAL SUGGESTIONS.

A small erosion of the trachea may give rise to an hemoptysis, which must be distinguished from a lung hemorrhage by the absence of pulmonary and constitutional symptoms and by the fact that the blood is in small clotted lumps.—*American Journal of Surgery*.

Pneumogastric paralysis after an operation involving manipulations about the nerve, e. g., removal of tuberculous cervical lymph nodes does not necessarily indicate that the nerve has been accidentally cut or tied. The condition may be transitory and result from traumatic or inflammatory irritation.—*American Journal of Surgery*.

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Editorial Comment.

Medical Expert.

For some years past, the medical expert has had little or no standing before our courts in cases involving considerable money and more particularly where the defence of insanity has been used following a murder.

There is, doubtless, very good reason for this attitude as exhibited in at least one case within the last five years, in which appeared the customary number of experts on each side of the case. The defendant was acquitted on the grounds of insanity and within two years was a free man. This verdict might have been justifiable from the humanitarian standpoint but not when our present system admits of an arrangement of three or four of our prominent physicians, most of whom are not experts in the work for which they are called, to serve in the capacity of experts, each of whose judgments is turned towards the side who has employed him, and to whom he should turn for his remuneration.

There are very few capital cases which will not admit of one or more diverse opinions when tried before the court or even in the consultation room. It is of the utmost importance that a physician's opinions in these cases should be absolutely unbiased, to be of any value to the court, and it was with this in mind that the Rhode Island law was submitted to the various county societies and finally to the State association for adoption, this last year.

We are now endeavoring to present this matter before the Maine Bar Association and it should be the duty of every physician to advocate this measure to every member of the Bar Association with whom he comes in contact. A copy of this law will be found in the Medico-Legal Department of this issue of the Journal.

The Cat Problem.

There can be little doubt that the cat is a conveyor of filth and disease. As such, she is being investigated by the Massachusetts State Board of Health for the possible part she plays as a carrier of the causative agent of anterior poliomyelitis. We believe that in the intimate, playful associations of cats with children, lurk dangers of real and probably terrible significance, and therefore, we look with favor upon the extermination of homeless felines and endorse the project to license all others. The findings of the Massachusetts Board of Health are awaited with not a little interest.

Typhoid Fever.

There is no foundation in fact for the oft repeated assertion that the source of typhoid fever in Portland is Sebago Lake water. The consternation prevailing is entirely disproportionate to the seriousness of the situation, and arises wholly from the mouthings of the ignorant who have learned that one of our local physicians recently reported the findings of a bacillus of the colon group in seven-tenths of a cubic centimeter of water taken from his laundry tap. The facts concerning the prevalence of typhoid during the past half dozen years are as follows:—

1906	73	1910	201
1907	47	1911	67
1908	152	1912	155 to date
1909	90		

In reviewing the statistics from the records of the Health Board, one must bear in mind that these figures include residents of the city and hospital patients from all sections of the State; that owing to the health laboratory, which examines suspected blood gratis, a greater number of physicians have reported their cases this year than heretofore, notwithstanding the reporting of typhoid was made compulsory in 1892. Again, there are families in which two, three and six are ill with the disease, and it is fair to presume, inasmuch as all were not simultaneously stricken, that the early cases provided infection for the later ones.

It is further stated that the number of cases is increasing at an alarming rate. This statement is likewise not borne out by facts, the contrary being true, as shown by the following figures available to anyone who will consult the records.

Aug. 3-10	15	Sept. 1-7	16
10-17	11	7-14	12
17-24	14	14-21	3
24-31	18		

Certain aspects of the situation, which is in no sense worse than in some former years or different from what has hitherto been the condition at this time of year in other cities of like size, certain aspects have apparently been intentionally overlooked in the desire of some physicians and laymen to make pecuniary gain at the expense of our city's welfare. These persons have not openly admitted the possibility of typhoid infection from milk, butter, ice cream or ice with which they cool their drinking water. Yet we venture to state that on the chances, these articles of food, rather than Sebago water, are the sources of infection. It is also reasonable to suppose, were our lake water polluted to a degree, that our cases would number 1,500 or 2,000 instead of 155. The lake *ought* to be thought of as a *possible* source of infection, but not unequivocally condemned as *the* source of infection.

May the time soon come when the State of Maine, through her State Board of Health, will give her citizens the opportunity to be inoculated against typhoid fever, as has recently the State of Indiana.

By prophylaxis alone can we prevent the development of the disease, eliminate the carrier, stamp out the infection. E. W. G.

False Therapeutic Claims Again Illegal.

The Food and Drugs Act of June 30, 1906, contained a provision which declared that any medicine is misbranded if its label contains any statement which is false or misleading "in any particular." This was held to apply to false therapeutic claims by the courts in which the federal authorities brought their cases to trial and as one result of this the many "headache cures" and "cough cures," etc., became headache remedies and cough mixtures, etc., in general the claims on the patent medicine packages became more guarded and less misleading. About a year ago, however, the United States Supreme Court rendered a decision which held that the law contained no provision against false therapeutic claims. Since then, patent medicine men have been gradually returning to their old, lying claims.

However, Congress, just before adjournment and in response to the general public demand, has passed an amendment which appears to restore the "Food and Drugs Act" to its former efficiency. The amendment provides that a drug or medicine shall be held misbranded, "if its package or label shall bear or contain any statement, design, or device regarding the curative or therapeutic effect of such article, or any of the ingredients or substances contained therein, which is false and fraudulent."

It should be borne in mind, however, that this amendment applies only to false therapeutic claims which appear on the label or package

of the medicine. It does not prohibit the exploitation of patent medicines through false claims in newspapers nor of "ethical proprietaries" with equally untrue claims in medical journals. For this reason physicians should impress it on their Congressmen that further legislation—legislation which will make lying illegal at all times—is urgently needed.

The Physician and the Pharmacopœia.

While most physicians no doubt appreciate that the pharmacopœia contains many therapeutically unimportant or worthless drugs few are familiar with the reason for this condition. Therefore the following information (J. M. A., July 27, 1912, p. 291) will be of interest as will also be the announcement that a satisfactory book of drugs may soon be available:

"Originally founded by physicians the pharmacopœia was intended as a collection of valuable drugs, prepared by an approved standard of methods, to be used by physicians. Soon, however, the pharmacist became prominent and then dominant in its preparation, and the character of the work was changed from a list of good drugs for the practicing physician to a standard of all drugs, adopted as official by the members of the Pharmacopœial Convention, dominated by the pharmacists. It was no longer a list of what the physician wanted but a collection of all drugs which the pharmacists thought should be included. In other words, it was assuming the character of a book of standards. In the succeeding conventions the same question arose. The physician desired that the pharmacopœia contain only such drugs as were found to be valuable in practical use, while the pharmacist wished to include all of the new drugs that seemed to him of commercial importance.

"The Council on Pharmacy and Chemistry has always contended, and the Journal agrees with the contention, that the pharmacopœia should contain only good drugs of practical use to the physician. This idea has grown and a long list of useless drugs was submitted by the Council on Pharmacy and Chemistry and various teaching physicians to the convention for elimination from the pharmacopœia. Just how far the committee will go in the elimination of these drugs is not known, but present appearances indicate that the wishes of physicians in the matter will be practically ignored."

In discussing a proposition regarding the publication of a book treating only of the really valuable drugs, the Journal A. M. A. notes that something has already been done toward preparing such a book in that a list of drugs has been compiled by the Council on Pharmacy and Chemistry, with the co-operation of teachers of therapeutics and materia medica and State board examiners and that a book on materia medica based on this list, will probably soon be published by the council.

Medico-Legal Matters.

Medical Expert.

Copy of Statutes of Rhode Island, Chap. 292.

"SEC. 18. Any justice of the supreme court, may in any cause, civil or criminal, on motion of any party therein, at any time before the trial thereof, appoint one or more disinterested skilled persons, whether they be residents or non-residents, to serve as expert witnesses therein; provided that the reasonable fees of such experts according to the character of the service to be performed, as fixed by such justice, shall be paid by the party moving for such appointment, to the clerk of the court at such time as the justice shall prescribe and the amount so paid shall form a part of the costs in the case. In criminal cases, in the discretion of the court, on request of the defendant, expert witnesses may be furnished for the defendant at the expense of the State, on such terms and conditions as may be prescribed by the court.

SEC. 19. Such experts being duly sworn before a justice or clerk of the court to make a faithful and impartial examination into the matters and things committed to them, and true report thereon to make according to the best of their knowledge, belief and understanding, shall thereon proceed to view and examine such persons, matters and things, to read and hear such evidence in such manner, times and places whether by attendance at the trial of such cause or otherwise, and to report their findings, views and opinions thereon, jointly or severally, orally or in writing, to the court when such cause shall be pending before or at the trial thereof, in such manner as the justice appointing them, or any justice of the court sitting in the case, shall prescribe; and such report, if in writing, shall form a part of the record of the cause and shall be produced in evidence at the trial thereof, and such experts shall attend at such trial until excused by the court; provided that any party to the cause may call and examine or cross-examine, any such expert at the trial as to the matters, persons, things, views, findings and opinions contained, mentioned or referred to in any such report, without further summons."

Recommend joint meeting with State Bar Association with the view of adopting above statutes or some modification of same.

Communicable Diseases.

The law of the State of Maine with regard to the reporting of tuberculosis is as follows:

"Chapter 47, Section 15. Tuberculosis is hereby declared to be an infectious and communicable disease, dangerous to the public health. It shall be the duty of every physician in the State of Maine to report in writing on forms to be furnished by the State board of health, the name, age, sex, color, occupation, place where last employed if known, and address of every person known by said physician to have tuberculosis, to the secretary of the State board of health within forty-eight hours after such fact comes to the knowledge of said physician. The name of the householder where the tuberculous person lives, or boards, and such other facts as may be called for on the blank reports issued from the office of the State board of health, shall also be included in the report. It shall also be the duty of the chief officer having charge for the time being of any hospital, dispensary, asylum, sanatorium or other similar private or public institution in the State of Maine to report to the State board of health in like manner the name, age, sex, color, occupation, place where last employed if known, and previous address of every patient having tuberculosis who comes into his care or under his observation within forty-eight hours thereafter. It shall also be the duty of said physician or chief officer to give notice to the secretary of the State board of health of the change of address of any tuberculous patient who is, or has lately been under his care if he is able to give such information. (Laws of 1909, Chapter 78, Section 2)."

"SECTION 16. In case of the vacation of any apartment or premises by the death or removal therefrom of a person having tuberculosis it shall be the duty of the attending physician, or if there be no such physician, or if the physician be absent, of the owner, lessee, occupant or other person having charge of the said apartments, or premises, to notify the health officer or secretary of the local board of health of said town of said death or removal within twenty-four hours thereafter, and such apartments or premises so vacated shall not again be occupied until duly disinfected, cleansed or renovated as hereinafter provided. (Laws of 1909, Chapter 78, Section 3.)"

With regard to the reporting of contagious diseases the law is not so explicit.

Chapter 47, Section 123 reads as follows:

"Whenever any physician knows or has reason to believe that any person whom he is called upon to visit, is infected with any of the diseases mentioned in section thirty-three, such physician shall within twenty-four hours, give notice thereof to the secretary of the local board of health, or the health officer of the town in which such person lives. (R. S., Chapter 18, Section 36, as amended by Chapter 78 of Laws of 1909.)"

Here we are referred back to Section 33, a quarantine regulation which reads:

"If a master, seaman, or passenger of a vessel, in which there is, has lately been, or is suspected to have been, any infection, or which has come from a port where any infectious distemper prevails, dangerous to the public health, refuses to answer, on oath, such questions as are asked him relating to such infection or distemper, by the local board of health of the town to which such vessel comes, which oath any member of said board may administer, he shall forfeit not exceeding two hundred dollars, or be imprisoned not more than six months. (R. S., Chapter 18, Section 66.)"

Therefore considerable latitude is left both to the person interrogated and to the local board of health as to what constitutes an "infectious distemper" "dangerous to the public health." Plague, cholera, yellow fever, leprosy and trachoma would obviously come within this category although they are not specifically mentioned. On the other hand, a list of diseases is mentioned in Section 120 which the householder in whose house they occur must report and it may well serve as a guide for the physician in making his report also. This list includes small-pox, diphtheria, scarlet fever, cholera, typhus or typhoid fever, cerebro-spinal meningitis, measles, membranous croup and whooping cough. Section 120, Chapter 47, reads as follows: "Whenever any householder knows or has reason to believe that any person within his family or household has small-pox, diphtheria, scarlet fever, cholera, typhus or typhoid fever, cerebro-spinal meningitis, measles, membranous croup, so called, or whooping cough, he shall within twenty-four hours give notice thereof to the health officer of the town in which he resides, and such notice shall be given either at the office of the health officer, or by a communication addressed to him and duly mailed within the time above specified, and in case there is no health officer, to the secretary of the local board of health, either at his office or by communication as aforesaid. (R. S., Chapter 18, Section 33, as amended by Chapter 33 of Laws of 1909.)"

Every physician should also be familiar with Chapter 47, Section 140, viz: "To provide for the control of diphtheria and other contagious diseases, local boards of health shall furnish antitoxin free to all indigent persons suffering from such diseases, in such manner as the State board of health may direct. (Law of 1909, Chapter 55, Section 1.)"

SURGICAL SUGGESTION.

If the administration of thyroid extract to a patient suspected of exophthalmic goitre increases the symptoms the diagnosis is more probable.—*American Journal of Surgery.*

Book Reviews.

Review of International Clinics, Vol. II, Twenty-second Series, 1912.

The International Clinics, edited by Henry W. Cattall, A. M., M. D., are published by J. B. Lippincott Co., and sell in cloth binding at \$2.00 per volume of about 300 pages.

Volume II, twenty-second series, contains a great deal of value to the specialist, as well as the general practitioner.

The management of Sunstroke — A lesson in hydrotherapy by Dr. Simon Baruch criticises severely the use of the ice bath in sunstroke which results in a mortality of about thirty-eight per cent. He favors using water from the cold tap and pouring this over the patient from a height of six feet or more, continually rubbing the patient. He follows this with a smaller stream of ice water, rubbing as before, until the body no longer feels warm. The patient is now dried and wrapped in blankets. After a half hour, if the patient has reacted, he is allowed to rest another half hour, if not treatment is resumed. The mortality under this treatment is under ten per cent.

Albert Abrams, M. D., opens up a new field of treatment in his paper, "Principles and Practice of Spondylotherapy."

His conclusions are (1) that many pathological conditions can be more easily and certainly controlled by spondylotherapeutic means than by the conventional measures. (2) that by the aid "of spondylotherapy a specific method of treatment has been found for the symptomatic cure of aneurisms and exophthalmic goitre, and that the results are almost immediate and practically permanent. (3) that the pathology of spondylology is founded on clinical physiology, and its methods embrace the therapeutics of the reflexes.

Dr. J. Madison Taylor throws a sidelight on treatment in his paper "Psychic Hypertension: Restoration of Mind Control by Motor Training in Relaxation." He says: "Loss of mental poise often nullifies good treatment, and, when not judiciously reckoned with, is capable of defeating the best remedial measures." Briefly, he advises, intelligent directions in forming habits of periodic relaxation, by alternations of definite, simple, primitive motor energizing, with insistence on equally clear-cut periods of absolute rest, stilling of the mind.

MEDICINE. A Lecture in the Present Status of Epidemic Poliomyelitis by Dr. Simon Flexner expresses a hopeful possibility of control over the disease by prevention.

Dr. Victor G. Heiser in his paper "Beriberi and Its Prophylaxis," is optimistic in his belief that this disease will be eradicated by educating the populace to the fact that the disease goes hand in hand with highly polished rice, and in this way eliminating the use of such rice as an article of food.

The dangers of the underfeeding of infants are indifferent to the quality and quantity of food values.

While education of the mother as to the necessity of nursing the baby and doing everything in her power to make her physically fit to give this nourishment will eliminate the bottle-fed baby.

Symposium on Anæsthesia covers the ground very completely.

Surgery:—Direct methods of examinations of the larynx, trachea, bronchi, œsophagus and stomach are explained with the use of the bronchoscope, œsophagoscope, and gastroscope by Dr. Chevalier Jackson.

OPHTHALMOLOGY. Dr. Walter B. Weidler: "Some Ocular Manifestations of Hysteria," gives cases of ptosis and loss of vision due solely to hysteria.

Dr. Meyer Solomon: "The Science and Practice of Eugenics or Race Culture," gives the sequel to his paper in Vol. I, International Clinics.

The National Insurance Act (1911) for the United Kingdom from the physician's standpoint, is dealt with by Dr. J. W. Ballantyre. This act brings up the contract doctor question about which there has been a considerable discussion in our own State in the past year.

As a whole, Vol. II, International Clinics is highly interesting and instructive.

This volume is devoted to the diagnosis and treatment of Medicine, Surgery, Ophthalmology, Obstetrics and Gynecology and Occupational Diseases and among the contributors we find such names as John B. Deever, Arthur Dean Bevan, R. Tait McKenzie, James K. Young, Charles F. Stokes of this country as well as Buchanan, Carmichael and other foreign authors.

Like its predecessors it is devoted absolutely to the newer things in medicine and is a most commendable work.

M. A. W.

Dayton's Epitome of the Practice of Medicine.

The Practice of Medicine. A manual for students and practitioners. By Hughes Dayton, M. D., formerly of the Cornell University Medical School, New York. New (2d) edition, thoroughly revised. 12 mo., 326 pages. Cloth, \$1.00 net. The Medical Epitome Series, Lea & Febiger, Publishers, Philadelphia and New York, 1912.

An extremely valuable work for hasty references by the physician as well as the student. It leads the pharynx, larynx and tonsils to a separate volume dealing with these special subjects.

The Osler classification has been followed which renders it a simple, as well as a comprehensive work.

We can readily recommend it to the busy practitioner and student of medicine.

Progressive Medicine.

Volumes XIV, No. 2, XV, No. 3, XVI, No. 4. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by Hobart Amory Hare, M. D., assisted by Leighton F. Appleman, M. D. Lea & Febiger, Philadelphia and New York. \$6.00 per annum.

March 1, 1912. In this volume are taken up Surgery of the Head, Neck, Thorax, Infectious Diseases, including Acute Rheumatism, Croupous Pneumonia and Influenza, Diseases of Children, Rhinology and Laryngology, Otology. Drs. Floyd M. Crandall, Arthur B. Duel, Charles H. Frazier, D. Braden Kyle and John Ruhrah are the contributors to Volume XIV.

June 1, 1912. The subjects taken up in this issue are Hernia, Surgery of the Abdomen, exclusive of Hernia, Gynecology, Diseases of the Blood, Diathatic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland, Nutrition and the Lymphatic System, Ophthalmology. Among the contributors are the following: Drs. John G. Clark, William B. Coley, John C. A. Gerster, Edward Jackson, Alfred Stengel.

September 1, 1912. This issue deals with Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood Vessels, Dermatology and Syphilis, Obstetrics and Diseases of the Nervous System. Drs. Edward P. Davis, William Ewart, William S. Gottheil, William G. Spiller are the contributors to Volume XVI.

Progressive medicine has always maintained a high standard as can well be expected from so well known an author as Dr. Hare. The above synopsis is the only recommendation necessary to the profession of Maine.

Practical Therapeutics.

A text-book of practical therapeutics with especial reference to the application of remedial measures to disease and their employment upon a rational basis. By Hobart Amory Hare, M. D., B. Sc. Fourteenth edition, enlarged, thoroughly revised and largely re-written. Illustrated with 131 engravings and eight plates. Lea & Febiger, Philadelphia and New York, 1912.

The fact that this is the fourteenth edition of a work appearing for the first time twenty-two years ago, gives one some idea of the opinion of the medical profession of the author's work and calls for very little elaboration. This work contributes a new introductory chapter, dealing with the use of salvarsan, tuberculin and vaccine therapy along with a description of Bier's method of treatment by artificial hyperaemia. Also the new ideas in regard to the employment of cardiac stimulants, as, for example, the use of digitalis, in connection with lesions of the bundle of His, are taken up.

Articles dealing with the treatment of diseases of the eye have been revised by Dr. George E. DeSchweinitz of Philadelphia. Dr. Edward Martin of Philadelphia has taken up antiseptics, gonorrhœa and syphilis, while Dr. Barton C. Hirst has had charge of the obstetrics.

We have no hesitation in saying that this is a very valuable work.

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County News.

CUMBERLAND.

PORTLAND MEDICAL CLUB.

The sixth meeting of the year was held September 5th, at the Columbia Hotel, with sixteen members present.

Arrangements were perfected for the opening meeting to be held in October, notice of which will be found elsewhere in this issue.

The paper of the evening was by Dr. Frank I. Brown. Subject, "Sexual Hygiene among the Young."

Dr. Brown showed the necessity of a parental training of a definite sort in sexual matters, and suggested methods for carrying this out. The paper was most interesting and thoroughly discussed.

PHILIP P. THOMPSON, *Secretary pro tem.*

KENNEBEC.

AUGUSTA MEDICAL CLUB.

The opening fall meeting of the Augusta Medical Club was held with Dr. H. W. Miller at the Insane Hospital, Sept. 16, 1912, at 8.30 P. M. Dr. Miller presented clinically "A Case of True Hermaphroditism." After the customary repast the paper of the evening on "Puerperal Eclampsia" was read by Dr. Farrell, every member taking part in the discussion.

H. W. MILLER, *Secretary.*

KNOX.

The regular meeting of the Knox County Medical Society was held on Tuesday, September 10th, in the City Councillor's Chamber at Rockland. A large number of members were present to hear Dr. Foescheimer talk on "Chronic Intestinal Auto-Intoxication."

Our society is extremely fortunate in having an opportunity to hear Dr. Foescheimer at least once a year as his summer home is in Camden, Me. It was a regrettable fact that every member of the association could not have been present.

H. W. FROHOCK, *County Editor.*

YORK.

The 70th quarterly session of the York County Medical Society will be held in North Berwick, Thursday, October 10th. Francis P. Emerson, M. D., 484 Beacon St., Boston, will, it is expected, present a paper entitled "Focal Suppuration of the Head with General Systemic Symptoms."

It is hoped that R. H. Marsh, M. D., of Guilford, president of the Maine Medical Association, will be a visitor at this meeting.

North Berwick has not had a session of the Y. C. M. S. during the seventeen and a half years of the society's existence.

A large attendance of members and guests is expected.

ARTHUR L. JONES, *Secretary*.

SURGICAL SUGGESTIONS.

Silver wire sutures and wire filigree are useful in those hernioplasties in which a large gap cannot be closed by approximation of the tissues, or in which the tissues are so thin that when approximated, they cannot be expected to provide support. In all other hernioplasties it has not been demonstrated that wire possesses any advantage over well chromicized catgut or kangaroo tendon. The prevention of recurrence, in hernioplasty, depends not on what the surgeon puts in his suture, but on what he puts his suture in.—*American Journal of Surgery*.

When there is persistent irritation of the throat without local cause, examine the chest. This may be one of the earliest symptoms of mediastinal tumor or enlarged bronchial glands.—*American Journal of Surgery*.

Irrigation of the throat with ice water from a fountain syringe will relieve the congestion and the pain in acute follicular tonsillitis.—*American Journal of Surgery*.

When confronted by an irregular rounded growth appearing to spring from the sternomastoid in the middle third of the neck, bear in mind the possibility of a carotid gland tumor.—*American Journal of Surgery*.

Ligation in continuity of the external carotid should not be close to its origin. The proximal clot may extend into the common, and be swept through the internal carotid, to the brain.—*American Journal of Surgery*.

Translucency in a scrotal swelling indicates, of course, the presence of hydrocele fluid. But if the shadow of the testicle within is unduly large the hydrocele is only a complication of some other condition, e.g., neoplasm of the testis.—*American Journal of Surgery*.

Paronychia may often be thoroughly drained by gently passing the knife point between the nail fold and the lunula without cutting the true skin. Disinfect with a drop of tincture of iodine, insert a tiny gauze drain and apply a small wet dressing.—*American Journal of Surgery*.

PERSONAL NEWS AND NOTES.

Dr. E. B. Silsby of Rockland, has returned from an extended trip through the Pacific Coast States, having been away two months.

Dr. A. W. Foss of Rockland, has nearly recovered from a compound fracture of tibia, sustained in a runaway, last summer.

Dr. H. E. Milliken of St. Barnabas Hospital is spending a vacation on his farm in Surry, Me. During his absence, Dr. E. W. Gehring will act as associate editor on the Journal staff.

Dr. H. W. Frohock of South Thomaston, has been appointed County Editor of the Knox County Medical Society.

Dr. P. W. Davis of Portland, has returned from his vacation.

Dr. F. P. Webster of Portland, who has been spending a couple of weeks at Rye Beach, has returned home.

Dr. J. D. Cochrane and family of Saco, have been automobiling through parts of Maine, during the past few weeks. The doctor and others with him met with a serious accident, Tuesday, Sept. 3rd, going from East Corinth to Bangor. With the doctor in the car were his wife, his sister, Miss Avilla Cochrane and Mrs. Cochrane's parents, Mr. and Mrs. Seth Hutchins of Lovell. A bad place in the road was responsible for what occurred. The wheels striking the uneven bedding, the steering gear snapped, the car plunged into a telegraph pole and the occupants were thrown violently into the road, with the exception of the doctor who had kept a tight grip on the steering wheel. All were badly bruised and shaken up and Mr. Hutchins had his leg broken just below the knee.

Dr. Harry A. Weymouth, Saco, Sheriff of York county, has been having considerable trouble during the past two months on account of an infected finger which resulted from a slight wound that occurred while attending a patient.

Dr. Charles M. Sleeper of South Berwick was elected a Democratic member of the Legislature on September 9th, for a second term.

Solon Bartlett, M. D., (M. M. S., '71), has been sojourning at his seaside cottage, Old Orchard, since early spring. Dr. Bartlett is a resident of Lowell, Mass., where he has been located during the past thirty-eight years. The condition of his health has been very critical during the past year, due to cerebral disease, with no prospect for recovery.

PORTLAND MEDICAL CLUB.

NOTICE.

The next meeting of the Portland Medical Club will be its first annual open meeting. Preparation of the program has been in the hands of Dr. Lucinda B. Hatch, and she has procured for the speaker Dr. Henry W. Miller, Superintendent of the Maine State Insane Hospital at Augusta. His topic will be "Eugenics," and the meeting will be held the evening of the 17th of October at the hall of the Pythian Temple. Each doctor of the State is cordially invited to attend and bring with him any who he thinks may be interested.

H. J. EVERETT, *Secretary*.

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[Reprinted from *Monthly Cyclopedic and Medical Bulletin*, June, 1912.]

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THE COMPETENT SURGEON AND THE ETIOLOGY OF APPENDICITIS.

By A. NOEL SMITH, M. D., DOVER, N. H.

Read before the August meeting of the Washington County Medical Society.

I am pleased to be present upon this occasion for several reasons. Here, in good old Washington County, battling with diseases and with the elements, as he filled the role of the "old-fashioned physician," in the old-fashioned way, my father walked and rode, visiting his patients throughout the towns of Baring, Upper Mills, Baileyville, Alexander, Meddybemps, Cooper, Crawford, Charlotte and Princeton, and often went into Wesley, Topsfield and other as distant towns; here it was that my happy boyhood days were spent, while, at the old Calais Academy on the hill, under that incomparable instructor, the late Hon. W. J. Corthill, my mind was trained and prepared for the higher work of life.

And now here, at this time, I am welcomed, not alone by brother physicians, which I feel to be a great honor, but by my brother in kinship, your esteemed president, and by you all, personally.

Fellows of this county society, thus are we Maine men together; and this means much, for there is no greater, grander State in all the union. And, today, none of us can claim or possess any advantage over the other, for we are equal.

What made our Civil War the greatest on record? Chiefly because similar spirits and like materials were pitted against each other. It was brother against brother, Greek meeting Greek, a family quarrel. And I put forth the declaration, which cannot well be controverted,

that had the southern men been equal to their northern brothers in number, with similar resources, our Civil War could have had no issue save that of full and complete extermination of both of the parties to the conflict.

During the Civil War, Henry Ward Beecher went to England in the interest of our government. While there, he was delivering an address before a mass meeting in London, when a southern sympathizer flung this question at him: "Why didn't you put down the war in three months as you said you were going to?" Back came the reply from Beecher like a flash of lightning: "Because we are fighting Americans and not Britains."

But more to my subject which is: "The Competent Surgeon and the Etiology of Appendicitis."

Appendicitis is, from the present viewpoint, essentially a surgical disease, and the remedy therefor should be applied by a surgeon. I am not a 1912 surgeon, nor the son of a 1912 surgeon, although my father enjoyed and probably merited quite a local reputation here in Washington county as a wielder of the scalpel among the surgeons of his day and generation. I essayed some general surgical work during my earlier professional career, where no one was much, if any, better prepared for such work than myself. However, believing that very few, if any, are able to take on progressive surgical work after passing the half century mark, I have let the newer surgery severely alone.

If one has not had the special early training requisite to good surgery, he has surely no moral, although possibly, a legal right to rob the patient of his best chance. Physicians, as a rule, know very little about the teeth, so they let them alone, and advice the services of a reliable dentist. I feel that we should limit ourselves to the kind of practice for which we have been fitted, both by nature and education. I have always been chary of attempting to do things for which I had not been trained and prepared, and I cannot comprehend why it should be thought disgraceful to be unable to do *everything*.

"If the talented physician is not always the skillful surgeon, if the painter is not a sculptor, if the musical genius does not possess talent similar to that found in a Marconi or an Edison, shall we stop to condemn any of these for the talent that is missing, or shall we not be glad and rejoice for the talent that is found?"

A medical man once remarked to me: "My idea of a good doctor is one who can do *everything*." This might well be anyone's true ideal, but who can be found to measure up to the standard? Not one, I venture to say, aside from the humble Nazarine. When the physician is not surgically qualified to operate, it does seem really criminal for him to attempt to do so, emergencies aside, and when more competent skill cannot be had.

Some maintain that the average doctor can train himself to do all of the routine operative work of the day, one M. D. going so far as to say that he is competent to operate in ninety-five per cent of all surgical work." But the really good surgeon knows better. As one says: (Dr. Emory Lanphear) "Of even more importance, however, is the teaching of surgical diagnosis. Today thousands of bellies are being opened by inexperienced and incompetent county-seat surgeons for purely imaginary conditions. The number of healthy ovaries removed because the women have Glenard's disease, neuralgia of the ileohypo gastric nerve, sexual neurasthenia, or what not, is appalling; the number of theoretically diseased appendixes extirpated is something astounding! And, on the other hand, the high mortality from unrecognized appendical abscess (or appendicitis diagnosed too late), the large number of fatalities from gall bladder and tubal infections, the infinite amount of suffering from chronic irritations which might be relieved by proper surgical treatment, all these are truly heartrending to the man who sees."

Dr. Geo. W. Guthrie of Wilkes Barre, Pa., wrote a very interesting article not long since for the Journal of the A. M. A., entitled "The Making of a Surgeon." He claimed that "although it is a good principle in life for everyone to be charitable in the judgment of others, there is a kind of professional patriotism that prompts one to take pride in his calling, and a true humanitarianism that leads us to consider the rights and claims of our fellow beings to the best that can be given them; that the question of special fitness should be raised; that all over the country there are men acting as surgeons to hospitals who never do any surgery except during the few months in which they are assigned to hospital duty; and that these so-called surgeons never go away to learn from real surgeons how the work should be done, they being so self-sufficient that they cannot be taught."

He received replies to letters written to several of the most prominent surgeons of the country, which answers are epitomized as follows:

Rodman says: "One to three years as first assistant to a surgeon of recognized standing."

White: "Experience, experience, experience."

Binnie: "Experience as assistant to a good surgeon."

Kelly: "Several years of hospital work under good men. I believe that training of this kind can only be secured by four or five years of hospital work."

Ochsner: "Assistant to a real surgeon for at least five years."

Murphy: "He should spend one to six years assisting a surgeon and diagnostican."

Munroe: "Apprenticeship in the service of a skilled surgeon from one to five years."

Mayo: "Five years as an assistant to some active hospital surgeon."

Now I addressed myself thus wise: "Dr. Smith, you cannot measure up to the standard established by these requisites."

Nevertheless, I am not debarred from *discussing* a surgical disease. That the vermiform appendix, in man, is not solely a vestigial structure but a specialized portion of the alimentary canal, is quite generally contended, because of its lymphoid tissue structure. That is, with the specialized cecal apex, there would appear to be the function of protecting the body against microorganisms in the ileocecal region. But there is not always success in this direction, hence disease. Of course, there are predisposing causes of appendicitis, such as infectious diseases, mechanical irritation, family predisposition, dental caries, etc. But whatever the predisposing cause may be in any given case, the exciting cause is always some infectious material, while the primal cause of all is, I firmly believe, a special infection. This disease may occur at all ages, having been noted even at the age of twenty-four days. In one thousand cases, McCook found one and seven-tenths per cent in children up to five years. All cases of abdominal trouble in children should be regarded as appendicitis until proved otherwise. The danger seems to be greater in the first years of life than later. As already observed, the exciting cause is bacterial. The bacillus coli communis is ever alert to invade the walls of the appendix. Other pyogenic organisms may act alone or in conjunction with it. Such havoc results that one writer says: (Dr. A. J. Ochsner) "Except in very rare cases in which the entire mucous membrane of the appendix is destroyed during the first attack, it is doubtful whether the patient ever completely recovers unless the appendix be removed. . . . The patient frequently carries about in his appendix a dangerous culture of bacteria which may at anytime place his life in peril."

And Alsberg says: "A person who has once recovered from an attack of appendicitis sits on a barrel of gunpowder."

But all of these conditions may be, and I believe are, secondary to some special germ which alone, aside from traumatism, can cause appendicitis.

As Swift long since wrote:

"So, naturalists observe a flea
Has smaller fleas that on him prey
And these have smaller still to bite e'm
And so proceed ad infinitum."

The ideal treatment of this disease is early operation, some having no faith in medicinal treatment, especially avoiding purgatives. One writer says: "First purgatives, then death." Over against this statement, the opposite extremist has the hardihood to say: "His appendixship was usually willing to shut up and keep quiet after he had a tablespoonful of powdered rhubarb and calomel on going to bed, followed in the morning with a pint of solution of 'salts,' or a tablespoonful or two of castor oil and turpentine. Mr. Appendix was usually satisfied with this and asked for nothing more, for fear, perhaps, that worse might follow. The death rate was not worth mentioning, neither was the doctor's fee."

In the May 31st, 1902 issue of *American Medicine* appeared the following from my pen, under the heading, "Cause of Appendicitis."

To the Editor of *American Medicine*: For several months, I have held the belief that appendicitis is caused by a specific bacterial element of some nature, and I have thus expressed myself to others from time to time. Upon no other hypothesis could I account for the rapid increase in frequency of the disease. Inability to diagnose cases in the previous generation will not cover all the errors, as the appendix cases now far outnumber the abdominal inflammations which occurred then.

I am pleased to note that Dr. Mitchnikoff is advancing the specific theory. Indeed, it is so stated in the daily press, which further adds: "*The Philadelphia Medical Journal* in reviewing the subject, says, 'the theory is the most plausible one yet advanced.'"

I trust that the bacillus which is to blame may be identified soon and described and a treatment devised to prevent a condition which at present requires the knife to remedy.

I have contended that if the bacillus of Eberth invades and causes characteristic lesions of the intestinal and mesenteric glands in typhoid fever, there is no reason why a special bacillus cannot and does not produce its own characteristic lesion in the appendix.

When my younger daughter was a small child, not old enough to decipher everything written by others upon her little blackboard, although able to follow copy quite well, her mischievous brother set a copy for her to transcribe over and over again. She laboriously and painstakingly wrote the words many times only to find out after awhile that they were not very complimentary to herself. The copy ran thus: "I think I'm smart, but I'm not."

So when nearly ten years since I advocated the single bacillus theory, for the etiology of appendicitis, in the light of the orthodox theories of today, some might well exclaim, "He thought he was smart, but he wasn't."

There seems to be no question at the present time but that bacteriologists and surgeons attribute the occurrence of the inflammation of the appendix to a number of organisms. Personal letters from them have demonstrated this.

Dr. John B. Murphy of Chicago, says: "There has been no specific germ found uniformly, or approximating uniformity, in acute infections of the appendix. We do not know why they should not be of certain varieties, but we *do* know that no specific micro-organism has been demonstrated. We can see every reason why any type of infective micro-organism should produce an inflammation in the appendix when it finds admission beneath the epithelial cells, as the same micro-organisms should in other structures of the body under the same circumstances. *At present*, I am of the opinion that appendicitis is not due to a specific organism."

Dr. John B. Wheeler of Burlington, Vermont, says: "It seems to me that as long as we find the colon bacillus, the typhoid bacillus, the tubercle bacillus, the pneumococcus, the streptococcus, the staphylococcus, and possibly the gonococcus, in different cases of appendicitis, it hardly seems necessary to assume the existence of a specific germ to produce inflammation of the appendix."

Dr. Maurice H. Richardson of Boston, states that he has no theory of the etiology of appendicitis that he knows certain facts, viz.: "Without apparent cause, the appendix and its mesentery, in whole or in part, may become suddenly necrotic. The bacteria present may be any pus-forming bacteria. Usually there is a mixed infection from the large intestine. In certain cases infection is owing to ulcerations of the mucous membrane, and these ulcerations themselves are owing to faecal concretions. Sometimes there seems to be an anatomical cause. Children of the same family will all have infections, which is owing to the family resemblances in appendixes, inviting infections.;" "I do not believe in any special germ, or any lesion characteristic of any special germ," Dr. Richardson writes, and adds, "I am sorry that I cannot tell you more."

One of our very greatest pathologists, Dr. W. T. Councilman of Harvard, writes me that he thinks "the prevalent idea is that a large number of organisms may produce an infection in the appendix." Yet he also admits that "the pathology of appendicitis is at the present time in a more or less uncertain position."

However, he rather knocks into a cocked hat my 1902 analogy to typhoid fever lesions by saying: "Lesions which are produced in the appendix are not characteristic as in the case of typhoid fever, but they are similar to the conditions which are produced in the tonsils in an acute tonsilitis. Indeed, the whole structure of the appendix in

point of crypts and relation of lymphoid tissue to epithelium is very similar to the structure of the tonsils, particularly in the proximal third of the appendix. Foreign bodies may produce appendicitis by causing necrosis of surface, thus favoring infection. The same thing is possibly true of faecal concretions."

Still, fellows, I do yet firmly adhere to my long-held opinion that some special bacillus is responsible for this disease, while other bacilli which are found in the field are either accidentally present, or act as secondary causes. It surely encourages me in my tenacity of belief when the great Councilman admits the uncertain position of appendicitis pathology today.

During the month of May, 1911, there occurred in the vicinity of Boston, and this year in Chicago and Baltimore, an epidemic of an acute tonsillitis, different from anything ever before noted in this country while physicians were all at sea as to the certain etiology of the disease. The English have called apparently similar outbreaks, "septic sore throat." There were more than one thousand cases in Cambridge alone. Eight hundred cases occurred in Boston, with nineteen deaths. The concensus of opinion was that physicians were dealing with a new and terrible disease. As one very intelligent woman wrote: "The death of Mrs. X. seems the very culmination of this tragic season. Cambridge is like a city of the plague. Whomever one meets, the talk is all of who is ill, who has had a relapse, who has died." Some are of the opinion that a new special germ caused this disease, a germ which has thus far eluded the microscopic eye, although Dr. Hamburger of Baltimore, thinks he may have found the guilty streptococcus. Thus, fellows, may it prove with the appendix, which has been well named the "tonsil of the abdomen." By all the laws of analogy, what, I ask, is to hinder the causal germ of appendicitis being still in hiding, even yet to be brought to light by improved methods of research?

After the preparation of the major portion of this address, I noted an editorial in a very recent issue of the Journal of the A. M. A., that opened with these very significant words,—which constitute a strong prop in support of my position. "The causation of appendicitis and of the consecutive peritonitis still constitutes a field for hypothesis and active investigation." This was called forth as the result of the investigation of Heyde in the very latest and most thorough studies of the bacteriology of appendicitis. He seems to demonstrate beyond question that the bacteria concerned are the anaerobic bacilli, that is, those living in the absence of free oxygen or air. Hence it is thought that an accurate understanding of the etiology of appendicitis is not possible without due consideration of the anaerobic bacteria. Indeed,

it seems that in these bacteria we must seek for the source of the severe intoxication from which patients suffer in this disease. If this prove true, a great stride of advance is thus made towards my specific theory, for, don't you see, the search is narrowed down to the immediate family of the guilty germ, so that the special member or bacillus may be more easily located.

But, fellows, if I occupy much more of your time you may desire to *spea*k the words to me that the sexton's wife *wrote* to her husband. In this particular church, upon this particular Sunday, a clergyman was supplying the pulpit for the first time. The sexton had been passing the plate for the usual offering, and was about to return the same to the altar. As he wended his way up the aisle, and came over against his own pew, his wife, evidently having forgotten something at home, handed a note to her husband. He, supposing it a notice to be read from the pulpit, in turn handed it up to the clergyman. Imagine the latter's surprise and consternation when he opened it and read these words: "Go home and shut off the gas."

However, before I shut off the gas, I will further note that I have had the hardihood to talk to you a little while concerning a surgical disease, although not a surgeon myself. This seems perfectly legitimate, for although we do not all work in the laboratories, we use the diphtheria antitoxin, the lactic acid bacilli, the serums, etc., in our practice. Pasteur, Leeurvenhock, Roentgen, many chemists and pathologists were, and are, not M. D.'s and Behring, Mitchnikoff, Flexner, and Ehrlick are not even engaged in the active practice of medicine, the early school days of the latter being not characterized at all by brilliancy in scholarship. He was graduated, we are told, from the university because he had done some special work with the lenkocytes, and not because he was specially competent in all his studies.

A good old country deacon, fairly wealthy, contracted the automobile fever. The fever raged to such a height that he was forced to purchase a machine. When he considered himself master of his auto, he called around one day and invited his pastor to ride with him. The good man accepted the invitation, and they were soon whirling along the highway at a goodly speed. The parson gripped the seat and nervously asked if everything was all right. Assurance was forthcoming and at the same time the speed was increased to sixty miles an hour. The preacher was excitedly alarmed, but he was again reassured. "Well," said the parson, "I hope the good Lord is with us." "I hope so, too," responded the deacon, "but if he is, he's going some."

Of course, I cannot claim equal consideration and distinction with the noted men to whom your attention has been directed, but the same principle obtains, in that I am enabled to contribute my minimum of

mental theoretical work, even though not fitted, like the surgeon to cope with a surgical disease in a practical manner. Thus, in a way, but far to the rear, do I feel to be in the distinguished company of Behring, Pasteur, Flexner, Ehrlich and others, and, if so, I am, like the deacon with his passengers, the minister and the good Lord "going some" and certainly in the right direction.

THE NEUROTIC OR FUNCTIONAL SPINE.

BY DR. T. F. CONNEEN, PORTLAND, ME.

Read before the Androscoggin and York County Medical Societies.

The most common type of neurosis which comes to the orthopedic surgeon is that in which the symptoms are largely referable to the spine. The irritable hyperasthetic back is very common and is perhaps associated more constantly with physco-neurosis than with any other one symptom, or set of symptoms.

The beginning of the trouble may be associated with traumatism to the back or it may follow in the course of the development of a train of general functional disturbances.

Many generations back in the history of the human family, all human creatures were able to start the race of life with the same equipment of physical and functional strength.

The profession and laity of the present generation would be relieved of an ever present problem, if all human creatures acted and reacted alike to the responsibilities of life, to the daily fight for bread, to the exacting demands of social responsibility, with its joys and sorrows, with all its cares and comforts, with all its successes and failures.

That so many fall short in being able to stand the tention of life's responsibilities and fail to measure up the average mental and physical standard, may be due to the following — First, traumatism. Second, some diseased condition, local or general, resulting in incapacity. Third, incapacity without local disease being clinically present and this third class may be devided into those overtaken by mental incapacity and those incapables, but mentally sound. It is to the latter class that I wish particularly to speak of.

The cases of this incapacity, in mentally sound persons, without any local pathological condition being clinically present, may vary

in shades all the way from those very slightly effected, to the chronic bed-ridden invalid who has long since abandoned all effort except that of complaint.

Some of these cases seem to be of congenital origin, consanguinity or inebriety of parents or presence in the parents of other neurosis or psychoses, having all been charged with casual responsibility. Our social and educational systems are perhaps answerable for many of the cases of acquired incapacity.

The more strenuous and exacting the occupation, the greater and less interrupted the tension on the nervous energies, the more numerous the victims. Neither age or race, neither sex or social condition seem to afford immunity.

Neurasthema is a fatigue neurosis due in part to malnutrition and in part to functional over-exertion, occurring in persons with hereditary or acquired predisposition.

The skin over the spinous processes may be hypersensitive and patients often wince under the most superficial pressure. In patients presenting the foregoing subjective and objective signs, there is often considerable variation in the localization of these most striking symptoms.

These patients are among the most difficult to handle of all chronic cases coming into the hands of a physician and because of the localization of many of the symptoms in the region of the spine or larger joints, they often seek orthopedic treatment though more frequently in the past they fell to the lot of the gynecologist. The reason of their coming usually is because the family physician can do nothing with the case and does not care to try or else he believes that there may be some physical basis for all the symptoms.

The danger of attributing too much significance to physical defect which may be present in such patients is great. It is essential to fix steadily before our own minds, after thorough and painstaking examination, the fact that the varied complaints of such patients cannot possibly be explained satisfactorily on the basis by local disease, but that they are probably due to a central cause acting through the nervous system, which for the want of a better name might be designated lack of nerve energy.

Perfect frankness should be used in explaining to the patient that there is no disease present to account for the symptoms, that the complaints are due to lack of nerve energy supplied to the tissues, that the tissue cannot discharge their function without the nerve energy; that it is just as necessary to proper function as the circulation of blood, and that it is now proposed to institute a line of treatment that will restore the proper amount and proper character of nerve energy.

that restoration of function will result; that relief cannot come, however, without the co-operation of the patient in a new direction. The greatest difficulty is experienced at the very outset, however, in convincing the patient that there is no local disease present. An improvement in the food supply of these patients is always of prime importance.

Chronic constipation is usually associated with the intestinal indigestion, hence, laxatives are continually called for which may also relieve a contributing auto infection from the intestinal canal, which may not be an inconsiderable eteologic factor.

To produce sleep, the regular use of narcotics should be certainly avoided, and also, if possible, the occasional hypnotic, as better results are obtained by hydrotherapeutic measures. The cold bath, followed by a brisk rub, later by electricity in some form, which, aside from any inherent therapeutic merits, also carries with it considerable suggestion. and this of itself, if used by the physician who possesses the qualification and judiciously combines the essence of phychic treatment with whatever other measures seem indicated, is the one who will be the most successful in the management of the cases.

It is characterized by exhaustibility of the nervous system, slight exertion causing prostration and bringing on the various distressing symptoms from which the patient suffers.

THE PATIENT.—The patients are generally women, more frequently unmarried (and peculiar as it may seem, many cases are observed among the unfortunate unemployed children of wealth, who have never known the absorbing interests of earning their daily bread and who have so little to do, that it is an effort to keep themselves physically fit).

The good housewife seems to be the sufferer in a great number of instances from the continual grind of her domestic routine. The ambitious college student, teachers and especially the school-girl furnish large number of recruits.

SYMPTOMS.—Those cases present a protean picture, headache, backache, tender spine, gastric and intestinal disturbance, abdominal pain and tenderness, constipation, disturbance and painful menstruation, hyperaesthetic and anesthetic areas, inability to work, weakness, discouragement, hopelessness, chronic incapacity or invalidism, and all this while they are yet young and in apparently good physical condition.

Temperamentally they are impressible, high strung individuals and have rather less than the normal amount of physical vigor. Occasionally there may be a slow phlegmatic person or one whose physical vigor seems to be unimpaired. They are characterized by the

readiness with which they become fatigued. Usually they are thin and more or less anemic, poor sleepers and without appetite except for the unnourishing articles of diet. In spite of professed inability to withstand slight use of their muscles, tasks requiring the exercise of surprising amount of strength will be undertaken and accomplished. The greater degree of physical fatigue of which they complain, the more they will undertake, that which requires further expenditure of energy. History often reveals an unstable nervous equilibrium in more or less remote numbers of the patient's family.

In these spinal cases, physical examination yields results entirely out of proportion to the subjective symptoms. Muscular tone is generally poor. There are frequently relaxations of ligaments, notably those about the knee joints, sacro illic articulations. Occasionally a weak ankle or pronated foot often exaggerates the condition. Ptosis of the abdominal and pelvic viscera are occasionally associated in the more pronounced type.

Spinal examination is characterized by normal motions; as a rule, by alterations in the physiological curves of spine, resulting either in a markedly round shouldered condition or one of extreme lordosis. Occasionally there will be a list to one or either side and an apparent spasmodic rigidity of the spine. This rigidity and list entirely disappears under gradual application of corrective force or when the recumbent position is taken. There is no permanent antero posterior deformity.

MECHANICAL.—Mechanical supports in the treatment of functional joint trouble holds a very important place. The muscles controlling the motions of a joint, or series of joints, like those of the vertebral column are fatigued by even a slight exercise of their own functions, and in the extraordinary receptive state of the nervous system of these patients, the response to this peripheral fatigue is a deepening of mental inertia. The patients are very much disinclined to make any physical effort and metabolic faults are added to those of the nervous mechanism. We must conserve muscular energy and spare the central nervous system from unnecessary task until reserve force has been accumulated, so it is desirable to have recourse to the use of apparatus.

In the spine there are often extreme degrees of postural deformity which result largely from muscular weakness and partly from the irretability of the intrinsic musculo-nervous mechanism of the vertebral column.

In the more extreme cases, a plaster jacket is desirable for a time, to be followed by a less vigorous support later, as improvement takes place.

Apart from the influence of suggestion the plaster cast employed has a definite physical, beneficial effect.

The cast may be followed in a month or so by a light steel back brace and this should be continued as long as hyperæsthesia persists. During this period, medical gymnastics and other desirable forms of physical therapeutics may be carried out.

If the pelvic articulations are the seat of relaxations which apparently contribute to functional disability, adhesive plaster strappings or a belt made of some strong elastic material or heavy drilling wide enough to reach from the trochanters to the anterior superior spines. This may be attached to the bottom of the corset and capable of being strapped tightly about the pelvis.

In traumatic cases in which a legal contest is pending, a speedy settlement very often results in a speedy recovery.

ECLAMPSIA.

BY O. E. HANEY, PORTLAND.

Read before the Portland Medical Club.

To my way of thinking, a paper prepared for reading before a body of persons of our vocation, should be of such a nature that its author may draw from his own personal experience (be that great or small) sufficiently at least to illustrate the patient features of the subject in question. I base this supposition from my own experience in the position of listener. For I had far rather learn of the successes and means of attaining them—of the failures and the reasons for them—in the personal experience of the author, comparing them with my own successes and failures in the same or a similar line of work than to listen to a perhaps more able and scientific article which is in the nature of a “rehash” of the best writers of the day, copies of whose works all may have and read in our leisure hours. I hope that this idea may meet with the approbation of those present, for I shall preface my paper this evening with the case histories of five patients whom it was my fortune to see during a period of time extending over four months, and illustrating, it seems to me, some of the different phases of the subject in question.

CASE I.

Miss O., twenty-four years of age, unmarried, primipara, of the blond type, slight in stature, weight neighborhood of one hundred and fifteen pounds, between eight and nine months pregnant. Had been having headaches, vertigo, dimness of vision and epigastric pain for several days. I was called for the first time in the early morning because her father, sleeping in an adjoining room, heard peculiar sounds in her room and upon investigation found the patient upon the floor in a semi-conscious condition. She had partially recovered from this before my arrival, though her mentality seemed rather dull and complained of severe pain in head and epigastrium. Suspecting trouble, I took some of her urine for examination and put her upon elimination treatment. About 1 P. M., I was called to the house in a great hurry. Found the patient in a terrific convulsion. Convulsion finally ceased, patient remained quiet and partially conscious for an hour. Another convulsion. Having, during the interval between my calls, examined the urine and found it with a heavy ring of albumen, I knew I could make no error in diagnosis. Asked for consultation and the family chose a local man who advised hot sweet oil poultices over the kidneys and await results. It was too late to get a consultant from out of town that day, except they came by night over an almost impassible road, so to please the family and give my consultant fair treatment, I applied sweet oil poultices and "awaited results." The result was that the patient had three more convulsions before seven o'clock that evening. I then strongly urged the family that they allow me to call an out of town consultant and trained nurse to come as early as possible the next day. This they finally agreed to do. In the meantime, labor pains were evidently going on after a fashion but had accomplished only a small amount of dilation of the os uteri. I administered hot packs, salines and sedatives all night. Patient had three more, seven convulsions during the night. Consultant and nurse arrived at 9 A. M. The patient was only dully conscious then, but the coma was not complete. This consultant agreed with me the uterus should be emptied if possible. Gave ether, dilated, applied forceps to a large misshapen head and after one-half to three-fourths of an hour of hard work for myself and consultant, decided to do a craniotomy in order to clear out the uterus. Craniotomy was done and foetus was extracted without rupture of any tissue. Placenta expressed by Crede method. Patient put to bed, hot packs were continued and as soon as conscious from anaesthetic Busham's mist in siphon soda and mg. So. were started. The patient had lost quite a little blood, so a subcutaneous injection of normal salt solution was given. In less than six hours from the time of delivery, the kidneys

and bowels began to assume an apparently usual condition and the patient made an uneventful recovery, is living today, apparently no worse for her experience, though it was some time, of course, before the albumen entirely cleared up from the urine.

There is somewhat of a question in my mind as to the advisability of a craniotomy in this case. Perhaps Cæsarean section should have been done instead. Yet there seemed, on examination, to be a large misshapen head and it was the advice of my consultant to do craniotomy with certain loss of the child (the future of which seemed problematical in many ways) rather than further jeopardize the chances of the mother. Besides we had no definite knowledge of fetal movements for several hours and the child may have been dead before the skull was ever perforated.

CASE II.

Mrs. M. Married, multipara, pronounced brunette, well developed woman, weight neighborhood one hundred and sixty pounds, seven to seven and one-half months pregnant. According to the history of the case, the patient had had similar trouble with a still born child. Two living children.

Was called for first time to see patient at about 5 A. M. Found patient in fairly good condition except for slight dullness in perception. Gave history of headaches constantly for two weeks' previous and marked dimness of vision. The husband, more or less nervous of course, gave a description of a "spell" which she had upon awakening him that morning that seemed to indicate a slight convulsion. As the patient lived six miles away, she had had another before my arrival. I examined and found that there was quite a little dilatation of the os and as labor pains seemed to be coming on well, I awaited results. At the expiration of two to three hours' time, she delivered herself of a dead foetus. With the use of dimetic remedies, she made a rather slow recovery. The albumen in the urine and dimness of vision remaining for some weeks.

CASE III.

Mrs. C. Nineteen years of age, married, primipara, well developed, weight neighborhood of one hundred and fifty pounds, decided blonde, has exophthalmic goitre, with quite a degree of exophthalmas, though not much enlargement of thyroid gland to be felt on palpation. Of the type to which this patient belongs I shall have more to say later. Perhaps some of my hearers will claim that such a case should not come under this classification but my reasons for so placing the case will be presented shortly. This patient came to

my office when six to seven months pregnant, complaining of headache, vertigo, spots before the eyes, epigastric pain, etc. I examined the urine and found heavy ring of albumen. I immediately put her on diuretic treatment, with the result that the woman had no convulsions though the above symptoms continued to grow worse until at eight months, she delivered herself of a dead foetus. The patient then made an uneventful recovery and since that time I have delivered her of a living child with none of the symptoms of her first pregnancy present at all from beginning to end of the second puerperal period.

CASE IV.

Mrs. P. Twenty-one years of age, married, primipara, well developed woman of pronounced brunette type, weight in neighborhood of one hundred and forty-five pounds. Had never previously treated or seen the patient as the family usually employed another M. D. For some reason at this time, I was called on an extremely dark night, in a severe rainstorm, to see patient who lived seven miles from my office. I was not even told, over the telephone, what sort of a case was entering upon, so did not take my forceps with me.

On arrival, found the woman at full term and having slight convulsions. Weak labor pains were going on and no dilation of the os had taken place. I gave bromides, chloral, small doses of morphine, epsom salts, and started hot packs. Patient seemed to be quieting down, mind seemed clearer and no immediate prospects of delivery. I could not deliver her as I did not have my forceps, so decided to go back home for the night, telling the family to call the family physician who was expected to have the case, if any further trouble developed. I heard nothing further from the case until about 5 P. M. the next day, when a telephone from the husband saying they wished me to come as they could not reach their family M. D., and his wife was having more "spells." This time the convulsions were more pronounced and as the os had become softened and somewhat dilated, the application of forceps was not difficult. A dead foetus was delivered with only slight nick of the perineum. On coming out of the ether, the convulsions seemed to return, so sent for trained nurse. The convulsions had disappeared before the arrival of nurse, however, and patient made uneventful recovery.

CASE V.

Mrs. G. Twenty years of age, married, slight in stature, weight neighborhood one hundred and fifteen pounds, blonde in type, primipara. I was engaged to take case but had never seen the patient until

the time of the following description. This call came about 4 A. M., and I thought from story told by the husband that the patient had had a slight convulsion. It was impossible to be sure of this, however, and as I had had no opportunity of examining urine, the only suspicious symptoms I had to deal with were the dull mental condition of patient and the meagre description of attack previous to my arrival, given by husband. I shall always regret that I did not make those symptoms of enough prominence to forcibly dilate the uterus and empty same. The patient responded with an effort to questions, the mind acting slowly. I debated in my own mind immediate delivery. But as I was without help of any sort and the surroundings were poor also, there had not been the opportunity to confirm my diagnosis by examination of urine, I decided to wait a little and watch the case.

I procured a small amount of urine for examination, told the husband to come to my office in the P. M. (if the patient was no worse before that time) for a different medicine and after watching the case with no further developments for an hour or two, I went home. While at the house, I gave mg. so. 4, diuretic tablets and instructions for drinking copious amounts of water. Having found a heavy ring of albumen, I gave the husband, when he came to office at 2 P. M., Basham's mist, in addition to above. On his return home he gave his wife the first dose of the Basham's mixture. The patient remarked how pleasant it was to the taste and immediately straightened out in a convulsion. A woman (because the husband did not dare to leave his wife) then walked a mile to reach a telephone. I had to drive four miles, consuming in all more than an hour's time. When I arrived, she was still in the same convulsion. I gave a few whiffs of chloroform and administered bromide and chloral by rectum, and in a few minutes the convulsion ceased. The patient immediately entered a state of deep coma and never came out of it. Labor had hardly begun, the os was dilated very little and quite rigid. I tried to get a physician to assist me but could not, and as darkness was coming on, I dilated the os sufficiently to admit and applied high forceps, delivering a large sized dead foetus with (I am sorry to confess) a partial laceration of perineum. This I repaired and all with no anesthetic as the patient was so deep in coma that she sensed nothing. I then hot-packed, did venesection and injected saline solution, gave croton in olive oil. As the pulse began to weaken and rise in frequency (from 120 at time of delivery to 140, then 160 and even higher toward the last) I gave small doses of strychnine but to no purpose. The patient died the next day at 4 P. M. This completes my small list of cases, and long before this point has been reached, each and

every one of my present hearers realizes even from my poor descriptions that the subject of my paper this evening is that dread disease which we term, for want of a better name, eclampsia. "Eclampsia" (according to the definition of Dr. Williams of Baltimore) is an acute disease which may occur in the pregnant, parturient or puerperal woman and is characterized by clonic and tonic convulsions, during which there is loss of consciousness, followed by more or less prolonged coma."

The definition given by Dr. Gould in his medical dictionary, by Dr. Peterson of Ann Arbor, Mich., and others, is practically the same as quoted above. While not attempting in my feeble capacity to change or criticize the definition of the term as applied by these authorities, yet it seems to me not amiss to raise a question, at least, as to the exact limitations of the term. Their definition of the term seems to hinge upon the "clonic and tonic convulsions during which there is loss of consciousness, followed by more or less prolonged coma."

I shall make no attempt to deny that such symptoms and conditions are *exactly* characteristic of a well advanced case of eclampsia. I should not attempt to deny that delirium, carphology, pea soup stools, rose spots and extreme weakness were characteristic of typhoid, or that a foul, sloughing, macerated and bleeding mass was a characteristic of carcinoma. Yet all of us have seen cases which we diagnosed as typhoid in which none of the above conditions prevailed, not even the rose spots or delirium and in which the patient retained a reasonable amount of physical strength from beginning to end. Those cases were typhoid, however, for the microscope showed the unfailing Widal reaction of the bacilli. We have all seen cases in which there was only an indurated mass or masses in the cervix uteri, perhaps extending out into the pelvis. We diagnosed those cases as carcinoma, operated or had them operated upon and upon examination by the pathologist, were told that the tissue was unmistakably cancerous.

Indeed, upon this early diagnosis rests the only hope of the patient for recovery. We should, indeed, be loth to delay our diagnosis of all cases of carcinoma and typhoid until we found the characteristic symptoms first mentioned. Why then, may we not have cases of true eclampsia with *only* those unmistakable symptoms of headache, vertigo, dimness of vision, spots before the eyes, precordial pain and above all that urine loaded with albumen and deficient in urea? Why may we not have eclampsia just as surely before the stage of convulsions and coma is reached as we may have a mild form of typhoid or awake to the fact that a certain tissue is malignant in nature only

when it breaks down, sloughs and furnishes its malodorous discharge as evidence? Clinging to such a belief, I have included one case among the five which I have just now outlined to you as a true case of eclampsia, though there were no convulsions or coma from beginning to end. The woman (believing as I do) cleared herself from the cause of trouble, and escaped the later stages of convulsions and coma by delivering a dead foetus at eight months.

As to the manner of occurrence, etiology, pathology, symptoms, diagnosis, prognosis and treatment of eclampsia, I shall have but little to say, simply touching upon each, as our works upon the subject have made us familiar with the classical case.

Statistics, whether made from hospital records or records of private practice, show a greater or lesser degree of frequency. A higher rate is obviously obtained from hospital records. But a fair estimate is stated to be once in five hundred births. It is estimated that from seventy to eighty per cent of all cases occur in primiparae. In my little experience, four of the five were in primiparae, evidently bearing out the experience of others. The condition is more liable (according to the writings of some authors) to occur when there is a twin pregnancy or condition of hydramnios. Neither of these conditions was present in any of my cases. A few authorities speak of the disease being more frequent in blondes than in brunettes. Of the five cases cited to you, three were blondes of a pronounced type and two were brunettes, fully as pronounced of the opposite type, black hair, eyes and dark skin, showing a seeming preference for the blonde type though not greatly overbalanced in these few cases. As to the time of the eclamptic seizure, whether anti-partum, intra-partum or post-partum, there seems a wide difference of opinion in point of relative frequency. The majority of authors, I think, agree that the intra-partum variety is most frequent. Of these cases, under my own observation, one had *no eclamptic seizure*, two were given an anesthetic before labor had fairly begun, one had slight convulsions at the onset of labor, but none after labor became well established and one passed into coma before labor had hardly begun. A classification of these few cases, therefore, would put all of them in the ante-partum variety, with only one extending to the post-partum or even intra-partum stage.

ETIOLOGY.—Theory after theory has been advanced as to the cause of eclampsia. Emerging as we hope we are from the day of the medical man of wonder, who, as the laity so commonly say "could look right through a person and tell their troubles" and entering upon a more scientific era, there are many things yet of the nature of which we are wholly too ignorant, and among these many, "Eclampsia."

Years ago and for many years, perhaps through its being recognized only by the presence of convulsions, it was considered to be a disordered condition of the woman's nervous system, peculiar to pregnancy. This view has long ago been abandoned. For many years succeeding this, probably owing to the condition of the urine, eclampsia was identified with uremia. Then came the idea that the circulation of ammonium carbonate in the blood was responsible for the trouble. This theory had seemingly passed into disrepute when it was recently revived by Dr. Williams and others in their work upon the increase of the ammonia co-efficient in the urine, an apparently established fact in all of these cases. In reference to this fact, I would cite an able article in the December number of the MAINE MEDICAL JOURNAL, written by Dr. J. B. Drummond.

For some years after the labors of our eminent bacteriologists had begun, several men tried to work out the theory of a bacterial origin for eclampsia. The result of their work seems largely problematical and has, I think, been generally abandoned. I am only running over these theories hurriedly without attempting to disprove, verify, or even give the names of the men doing the greatest amount of work with each. I pass over the subject of etiology by simply stating that the latter day workers on the subject are more generally agreed upon some auto-intoxication, just the nature of which has never been conclusively proved.

The conclusion seems to be that some toxic material, bacterial, chemical or whatever its nature may be, collects in the system instead of being eliminated by the excretory organs, increases the toxicity of the blood serum, which further aggravates the renal and hepatic lesions until, if allowed to go on, we have the dread eclampsia upon us in full working order.

During the past few years, a number of noted workers have advanced the theory that the intoxication may be due to, or at least its action assisted by, some product or products of the foetal metabolism. Observations seem to show that there is no physical reason why the osmotic changes should not work from foetus to mother, as well as mother to foetus. Cases have also been reported in which the child, at or immediately after birth, suffered from convulsions exactly similar to those afflicting the mother. This would seem to prove that the same toxic condition affecting the mother exists in the child. These facts make this theory a very attractive one to me. We know that the maternal organism must have a much greater load to bear at this time and its excretory organs in proportion with the rest. What is more natural than that it should sometimes break down under this extra strain and refuse to bear its burden? In the great majority of

cases, the convulsions stop and the mother recovers when relieved of the foetus, going a long way, it seems to me, to prove that the foetus may be largely, at least, responsible for the trouble. In four of the five cases which I have cited to you, the convulsions and even coma (if present) ceased after delivery. In one case it did not, and I lost the patient. What is more natural to suppose than that the mother's organism had become so thoroughly impregnated with the poison in those cases when no relief follows delivery, that it cannot be sufficiently cleared out by any means now at our command in time to save the life of the mother, so much as to what is known concerning etiology. Sufficient to say, it is at present unsatisfactory at best. We hope that the light of science may be more fully thrown upon it in the near future, and that its rays may divulge something by which we may avoid the present darkness and groping.

PATHOLOGY.—Much has been said, little has been proved. Changes—macroscopically and microscopically—have been found at autopsy in several different organs of the body. Some of the conditions found in the uterus, placenta, brain and other organs may have been due to septic infection which frequently goes hand in hand with the eclampsia or follows closely on its heels. But unmistakable signs seem to be found in the kidneys and liver. Those of the kidneys have been known for a long time and as I have said, placed eclampsia, nephritis and uremia in the same category. But from the fact that all patients known previously to have a chronic nephritis do *not* have eclampsia, there must be some widely dividing line. There are, however, findings in the liver which seem to be pathognomic. Different observers have declared that they have always found certain apparently necrotic areas certain small, irregular reddish or whitish spots scattered through the entire organ but most frequent in the region of the small portal vessels. A few observers think that this is the primary lesion of the disease and go so far as to say that the entire process is an impairment of the hepatic function—in other words a hepato-toxemia. Their theory seems a reasonable one from the fact that liver degeneration is associated with increase of the ammonia coefficient in the urine as is found in these cases. Other men had thought they were sure that the action of the kidneys was held in abeyance. But we have since had methylene blue demonstrated in the urine of an eclampsia patient shortly after the administration of the drug, thus showing that the kidneys were still active. The theory of the hepato-toxemia advocates may be as ruthlessly exploded before the final settlement of the question. Be that as it may, these conditions do exist, as every day practitioners we must combat them as well as we can and await the results of the more comprehensive scientific explorations.

SYMPTOMS.—As to symptoms, according to my observation and reading, there may be as great a diversity as in typhoid, appendicitis or gall bladder disease. I would divide them into three classes, premonitory symptoms, convulsions and coma. On the one hand we may have a period extending over several weeks, during which the patient complains of listlessness, headache, dimness of vision, blurring of eyesight, spots dancing before the eyes, vertigo, indigestion, edema of the face, extremities or both, and what has seemed to me quite a constant symptom, pain in the epigastric region. When these symptoms are backed up by that tell-tale urine with its load of albumen, deficiency of urea and increase of the ammonia coefficient, we may look out for trouble. On the other hand an eclamptic convulsion may come without warning—"like a bolt from a clear sky" as one writer has expressed it. The absolute truth of that statement is to me doubtful, however. It may come without warning to the attending physician, but to me it is probable that the patient has been having some of the above symptoms previously. Like many of our patients, she has said to herself from day to day, "Oh, this will be all right tomorrow," until without warning to her physician a convulsion is "on." It is said that a convulsion may come while the patient is sleeping. At any rate in three of the cases outlined to you at the beginning of this paper, the first convulsion came in the early hours of the morning. The coma following the convulsions may be transient, clearing up after a little time following each convulsion, or it may be continuous until the condition is relieved or death intervenes.

DIAGNOSIS.—The diagnosis of a well developed case with its convulsions and coma is unmistakable, if we can exclude epilepsy, alcoholism, narcosis and hysteria. It is the diagnosis of what seems to me to be the incipient stage with its chain of symptoms such as I have outlined above that should require our most careful thought and attention.

PROGNOSIS.—The prognosis is always serious. The maternal rate of mortality is given at from twenty to twenty-five per cent. It is generally conceded that the post-partum variety is fraught with less danger to the mother as she then has passed the ordeal and has only her own organism to look out for and vice-versa with reference to the ante- and intra-partum varieties. The rate of mortality for the foetus is stated at from thirty-three to fifty per cent. Personally, I have never yet seen a living foetus. That may be a circumstance or it may be due to some fault of mine, but such has been my experience. It is almost impossible to predict the outcome in individual cases. Some passing into a state of coma and then death after a very few convulsions (as one of my cases did), others will survive twenty-five or

thirty convulsions and if then relieved will recover. A good, firm, full pulse between attacks is a good sign, of course, while a thin, feeble pulse, especially if accompanied by a light temperature has an unfavorable outlook, at any rate it is decidedly unwise to give definite opinion as to the outcome of any given case to the relatives or anxious friends.

TREATMENT.—Treatment of eclampsia may be divided as in most diseases into the prophylactic and curative. The prophylactic seems to me to be far the more important from our point of view, as physicians. The first point it would seem to me best to emphasize is: Instruct every pregnant woman in the latter half of her pregnancy to bring or send some of her urine for chemical analysis every three weeks or oftener. I know as well as you that in the class of people with whom we sometimes deal that is more easily said than done. But in most cases, I think, it is possible. Now having examined the urine and found an alarming percentage of albumen, an increase in the ammonia coefficient and a diminished amount of urea, our duty to ourselves and patient is to begin our treatment for elimination.

I have no one particular outlined course or formulated action for this purpose. Diuretics are, of course, the main indication in conjunction with catharsis. I frequently use *Liq. Ferri et ammonii acetatis* (Basham's mist) with aerated or carbonated water in copious amounts, such as Poland water, Apollinaris, bottled siphon soda or even plain water. This treatment has apparently produced very satisfactory results. But the principle of diuretics is the one main indication to be borne in mind.

If the albumen does not clear up and the symptoms appear to grow worse instead of better, then the question arises what course to pursue. Some very excellent obstetricians advise the use of such drugs as *betratum viride* in huge doses and expectant treatment. But it is my belief that we as physicians are not only justified but that it is our duty to induce labor for the safety of the mother. According to my experience, we are almost sure to lose the child anyway and the sooner we clear out the cause of trouble the better for the mother. I think that more and more of the best obstetricians are advancing this idea. For unless this be done, we are simply lying back on our oars and trusting to nature and good luck to win out, which they don't always do.

The curative treatment deals with the method of action if we find ourselves in the midst of the convulsions and other phenomena of the later stages of the disease, although I don't know that this is in reality any more of curative treatment than what I have outlined under the prophylactic. However, treatment is usually so described and I will leave it as I have begun. Finding the patient in convulsions, our first duty must be to stop these convulsions if possible. The sedatives, the most powerful at our command must be brought into

use for the time being—chloroform at the onset of each convulsion, morphia in good sized doses (although this was formerly thought to be contraindicated, chloral per rectum in 20 to 30 gr. doses, etc. Our next duty, whether labor has begun or not, is to empty that uterus. If a good amount of dilatation has taken place, carry the anesthetia to full anesthesia (unless coma is deep enough to keep the patient quiet) and deliver with forceps. If dilatation is not sufficiently complete, then it must be made so. The Barnes or other bag to be inflated with air or some sterile fluid has been advocated and is doubtless a most valuable adjunct. Personally, I have used only my thumbs, getting the cervix down far enough to grasp and putting in first one thumb, then both and by gradual dilatation, I believe it can usually be opened up sufficiently to admit the forceps as the cervix is pretty well thinned out at that stage of the pregnancy.

Having produced version or applied the forceps and delivered, the next step is the ridding the system, as far as possible, of the poisonous material. The beginning of this is sometimes slow as the patient is usually unconscious and not able to swallow much liquid. Two or three drops of croton oil mixed in olive oil and put well back on the tongue is advisable to evacuate the bowels. Rectal enema of Mg. So. 4. Glycerine and water may also be of service. Now we can advantageously bring diaphoresis into use and for this purpose the hot pack is most acceptable. I mean by this enveloping the entire body of the patient in heavy woolen blankets wrung out of as hot water as can be borne without burning and keeping up a constant steaming by changing the blankets every fifteen or twenty minutes. One of the best methods of elimination with the patient in this condition is, I believe, bleeding and introduction of normal salt solution intravenously or by hypodermoclysis. The third stage of labor if not hurried will cause some loss of blood, but if the pulse is fairly strong, I believe in opening a vein and extracting more until perhaps five hundred cc have been withdrawn. Then replace this with an equal amount of normal salt solution, either intravenously or under the breast, buttocks or wherever seems most convenient for the occasion. As I have said, some men now advocate the hypodermic administration of veratrum venide or even pilocarpine, though the latter is to be feared for its action in causing edema of the lungs. But it seems to me that one of the quickest and surest means of ridding the system of the trouble is the extraction of the largest reasonable amount of blood and its substitution with normal salt solution. This procedure not only flushes out the system but by thinning out the blood we have withdrawn just so much of the toxins. But with a given case well under way with convulsions and the ever deepening coma, we are fortunate indeed, if we succeed in stemming the tide with whatever of medication that we now have at our command. In conclusion I will say that before I am called upon to treat another, I hope that medical science will have paved the way for a smoother road in the management of this unfortunate class of cases.

Necrology.

WILLIAM WALLACE THOMAS.

(1838 - 1912.)

Dr. William Wallace Thomas, a prominent citizen and medical practitioner of Yarmouth, Maine, died in Yarmouthville, June 20, 1912, after a lingering illness of several months. He was born in Oxford village, Maine, June 14, 1838, the son of George Wallace Thomas and Anne Blockinberg, his wife. He was educated in the common schools of the town and at Hebron Academy. He moved into Massachusetts with his parents when about twenty years of age but in 1862 returned to Maine and enlisted for nine months in the Twenty-third Maine Volunteer Infantry, in which he served as sergeant. At the conclusion of his term of service, he renewed his medical studies with Dr. Josiah Carr at Mechanic Falls and likewise attended lectures at the Medical School of Maine, where he obtained his degree in medicine in 1869; he settled in Yarmouthville in 1870, and practiced there successfully until his death, more than forty years. Naturally a modest and retiring man, he kept much to himself, but served faithfully on the school board of the village community, also was a member of the State legislature for a term or two and did good service. He belonged to many local societies, and gained and maintained the steady reputation of a trustworthy country practitioner of medicine.

Dr. Thomas married, June 20, 1877, Miss Clara M. Smith, by whom he is survived, as well as by a son who does not, however, practice medicine in his father's footsteps.

J. A. S.

SURGICAL SUGGESTION.

Splinters of hard wood, like pieces of glass, may become encysted in the tissues, and can often be drawn out whole by one end. But soft wood, and especially old wood, breaks on traction, and unless the wound is made large enough to expose it all, even very large fragments may be left, unrecognized, in the tissues.—*American Journal of Surgery.*

In removing a foreign body from a joint none but an uncontaminated gloved finger should be permitted in the wound, and that no more than is necessary.—*American Journal of Surgery.*

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Editorial Comment.

Prof. Dr. Vulpius.

During the past week, the State of Maine and her medical profession have been honored by a visit from the distinguished Professor of Orthopedic Surgery, Prof. Dr. Oscar Vulpius of Heidelberg. This visit is peculiarly gratifying to us inasmuch as it was in recognition of the high character of work done by one of our own colleagues, Dr. E. G. Abbott, that this leader of German thought in the orthopedic world came to America.

As is perhaps not generally known, the University of Heidelberg, founded in 1386, is the oldest university in Europe, the University of Prague being second. In this old institution of learning, Professor Vulpius created the department of orthopedics eighteen years ago, of which he is now the head. Aside from lectures on his specialty and other didactic work as lecturer on medical insurance, he has charge of the clinic of orthopedic surgery of one hundred and twenty beds and of the Home for Crippled Children of eighty beds, both in Heidelberg; and a clinic of two hundred beds near Heidelberg, known as the Clinic of Joint and Bone Diseases for Adults and Children. Nor does this complete the list of the doctor's activities and interests.

He still finds time to edit the "Centralblatte fur Orthopadische Chirurgie;" to write books, two of which "Treatment of Anterior Poliomyelitis" and "Orthopedic Surgical Technique" have recently been published in English. Besides active membership in many European scientific societies which necessitates a reading and speaking knowledge of German, French, Italian and Spanish, he is a member

of the American Orthopedic Association and speaks English remarkably well.

Those who availed themselves of the opportunity to see him operate at the Children's Hospital were impressed no less with the mechanical ability displayed than by the calm and accurate judgment exhibited.

A man of charming personality, who loves and is loved by his fellowmen; a consummate workman; a perfect artisan; staunchly German in thought, method and inspiration; withal a giant, is Professor Vulpius.

E. W. GEHRING.

The Third Clinical Congress of Surgeons.

The third Clinical Congress of Surgeons of North America will be held in New York, November 11th to 16th. Last year the Congress was held in Philadelphia, and was pronounced by all to be the most successful meeting of medical men ever held in this country, the evenings being devoted to papers and social functions, while the entire day is given to the clinics in the various hospitals to which all members of the Congress are eligible.

Dr. W. L. Cousins of Portland is endeavoring to arrange State of Maine headquarters at the Waldorf and would be very glad to hear from all Maine men who are planning to attend the session.

Vermont State Medical Meeting.

The 99th annual meeting of the Vermont State Medical Society was held in Montpelier on October 10 - 11. A large number of members were present and papers of unusual interest were read. Dr. Bingham H. Stone, Director of the State Laboratory of Hygiene, was elected President of the Society for the ensuing year and it was voted to hold the next meeting, which will be the Centennial of the Society, in Burlington on October 9 - 10, 1913.

The American Surgical Association.

The American Surgical Association has appointed a committee consisting of Drs. William L. Estes, South Bethlehem, Pa.; Thomas W. Huntington, San Francisco, California; John B. Walker, New York City; Edward Martin, Philadelphia; and John B. Roberts, Chairman, 313 S. 17th Street, Philadelphia, to report on the Operative and Non-operative Method of Closed and Open Fractures of the Long Bones and the value of radiography in the study of these injuries. Surgeons, who have published papers relating to this subject within the last ten years, will confer a favor by sending two reprints to the Chairman of the Committee. If no reprints are available, the titles and places of their publication are desired.

JOHN B. ROBERTS, *Chairman,*

313 S. 17th Street, Philadelphia.

***Official Inspections.**

Opened Shell Fish.

The definition of opened shell fish under the published food standards for Maine is: Opened shellfish are from unpolluted beds, and are opened, packed and shipped under sanitary conditions in sanitary containers without the addition of water or direct contact with ice.

Oysters.

In October, 1909, the following standard was published for Maine: "Opened oysters sold in bulk shall not contain ice or added water, nor more than seventeen per cent by weight of free liquids, nor less than ten per cent by weight of total dry solids." These limits were adopted after careful examination of both solid packed and adulterated goods. It was found that the free liquids which were drained from pure oysters would not exceed sixteen per cent and usually ran much under that figure, while the free liquids from the iced oysters sometimes ran as high as sixty-five per cent. It was found further that the oysters themselves after being freed from the liquid had taken in water so that the actual meat of the watered stock was only eight and six-tenths per cent, whereas the meat of the solid pack was thirteen and four-tenths per cent. Although the present definition of shell fish does not mention the chemical composition, oysters that come within these limits are passed so far as added water is concerned.

In Official Inspections 30, the results of the examination of fifty-six different samples of oysters, purchased in different parts of the State, were reported. Of these, seventy-one per cent were passed as within the above limits, and as being reasonably good. Since those results were published the station has examined fifty-five samples of oysters taken, as before, in various parts of the State, and the results of the examination of these samples were found to be practically the same as the first lot. Seventy per cent of the fifty-five were passed as being within the limits of the standard as good unadulterated oysters. In most of the cases where the oysters carried too much water, prosecutions were commenced and the dealers paid a fine without carrying the cases to court. A few of the cases were dropped without prosecution after obtaining a second sample which proved to be much better than the first.

The results here published, compared with those published over a year ago, do not show the improvement in the conditions under which these goods are sold which should be shown, and as the oyster season is again about to commence, the dealers are cautioned to exercise all care that the goods which they handle are above standard.

When the oysters are purchased, written guarantees should be obtained, stating that these goods are in accord with the requirements of the Maine Food Law. Water should not be sold as oysters, and if in transportation free liquids separate and rise to the top of the can, this free liquid should be poured off before the oysters are dipped out and sold. Ice should never be placed in the same receptacle as the oysters, as the melting of the ice will lead to adulteration with water.

A few years ago, it was the almost universal practice in this State to sell oysters preserved with borax or boric acid. It is believed that this practice has entirely ceased, for not for many years has any of this preservative been detected in any of the oysters examined.

Clams.

The situation in regard to clams has not seemed to improve very materially. Sixty-five per cent of the samples here reported carried over twenty-five per cent of free liquids. There would seem to be no reason why clams should not be sold in as solid a condition as oysters. Clams, when properly dug, washed, opened, rinsed and drained, will not carry much, if any, more free liquids than the best oysters which are found upon the markets, and clams which are not soaked in any way should contain at least twenty per cent total dry matter.

In Official Inspections 35, a description of the method of digging and preparing clams in this State was given. The dealers and shippers of clams in this State nearly all agreed that clams would not keep much longer than twenty-four hours in their own liquid, and it seems to be the almost universal practice to open the clams as promptly as possible after digging and throw the clam liquids away and then wash the clams in fresh water. The practice of leaving some or all of this fresh water in contact with the clams, as has been done in the past, results in a swelling of the clam meat in a manner similar to the results obtained from the floating of oysters and results in fraud, and dealers and producers are warned that prosecutions will be commenced in all cases where evidence is obtained that the clams have been soaked or adulterated in any way.

The same caution which has been given in regard to oysters applies in the handling of clams. *Written guarantees should be obtained from the people from whom these goods are purchased. Water should not be sold as clams. Ice should not at any time be placed in the receptacle in which clams are stored.* That the floating or soaking of clams with the resulting adulteration can be detected has been clearly demonstrated by samples opened and examined in this laboratory.

Apparently none of the samples of clams reported in the following table are free from adulteration. The best sample of all, No. 10259,

does not contain as much dry solid matter as unadulterated, unsoaked clams contain, and this sample does contain more free liquids than should be present. The amount of free liquids in the clams can practically be regulated at will by the dealer, and there is no excuse for selling water as clams.

Among the samples of clams reported there is not one which does not contain much more free liquids than the best oysters which are reported, and there is not one which contains the amount of total solid matter which unsoaked clams should contain. It is the intention to have the inspectors obtain samples of clams during the coming season, and in all cases where there is evidence of adulteration and fraud, hearings will be appointed and prosecutions commenced.

*August Bulletin of Maine Agricultural Experiment Station, Orono, Me.

Conference of State Secretaries.

One of the most important meetings since the reorganization of the American Medical Association at St. Paul, in 1901, was the Conference of the Secretaries of State Societies, called by the Committee on Uniform Regulation of Membership at the Association headquarters, Chicago, October 23 and 24. This committee was appointed in 1908, in accordance with a recommendation made in the Secretary's report for that year. At the Atlantic City session, last June, the committee summarized its reports for the last four years, and recommended that a conference of State secretaries be authorized to consider the entire question of membership conditions in the county, State and national organizations. This recommendation was referred to the Board of Trustees and a conference between the committee and the State secretaries was authorized by the Board of Trustees, to be held at the same time as the October meeting of the Board. Appropriations were made for paying the expenses of all state secretaries who attended the meeting. The conference was called to order at 10.30 A. M., Wednesday, October 23, at the Association building in Chicago, by Dr. Thomas McDavitt, secretary of the Minnesota State Medical Association and chairman of the Committee on Uniform Regulation of Membership.

THE ATTENDANCE.

Thirty-eight States were represented, the roll showing the following attendance:

Dr. W. W. Watkins, Phoenix, Ariz.
 Dr. C. P. Meriwether, Little Rock, Ark.
 Dr. Philip Mills Jones, San Francisco, Cal.
 Dr. G. W. K. Forrest, Wilmington, Del.
 Dr. W. C. Lyle, Augusta, Ga.
 Dr. E. E. Maxey, Boise, Ida.
 Dr. E. W. Weis, Ottawa, Ill.
 Dr. Charles N. Combs, Terre Haute, Ind.
 Dr. J. W. Osborn, Des Moines, Iowa.
 Dr. L. R. DeBuys, New Orleans, La.
 Dr. W. B. Moulton, Portland, Me.
 Dr. W. S. Gardner, Baltimore, Md.
 Dr. H. D. Arnold, Boston, Mass.
 Dr. Wilfred Haughey, Battle Creek, Mich.
 Dr. Thomas McDavitt, St. Paul, Minn.
 Dr. E. F. Howard, Vicksburg, Miss.
 Dr. E. J. Goodwin, St. Louis, Mo.
 Dr. H. D. Kistler, Butte, Mont.
 Dr. Joseph M. Aikin, Omaha, Neb.

Dr. Martin A. Robinson, Reno, Nev.
 Dr. D. E. Sullivan, Concord, N. H.
 Dr. Thomas N. Gray, East Orange, N. J.
 Dr. R. E. McBride, Las Cruces, N. Mexico.
 Dr. John Ferrell, Raleigh, N. C.
 Dr. H. J. Rowe, Casselton, N. Dak.
 Dr. J. H. J. Upham, Columbus, O.
 Dr. Claude A. Thompson, Muskogee, Okla.
 Dr. M. B. Marcellus, Portland, Ore.
 Dr. C. L. Stevens, Athens, Pa.
 Dr. J. Perkins, Providence, R. I.
 Dr. Edgar A. Hines, Seneca, S. C.
 Dr. Perry Bromberg, Nashville, Tenn.
 Dr. H. Taylor, Fort Worth, Tex.
 Dr. W. B. Ewing, Salt Lake City, Utah.
 Dr. C. H. Beecher, Burlington, Vt.
 Dr. Grant Calhoun, Seattle, Wash.
 Dr. Charles S. Sheldon, Madison, Wis.
 Dr. W. H. Roberts, Sheridan, Wyo.

No representatives were sent from Alabama, Colorado, Connecticut, District of Columbia, Florida, Kansas, Kentucky, New York, South Dakota, Virginia and West Virginia. No effort was made to secure the attendance of the secretaries of the Hawaiian Territorial Medical Society, Medical Association of the Isthmian Canal Zone or the Philippine Islands Medical Society, as these secretaries were too far removed from the place of meeting to make it possible for them to attend.

THE PROGRAM.

The following program was carried out:

1. Call to order, Dr. Thomas McDavitt.
2. History and Development of Membership in the American Medical Association and Its Component Parts, Dr. F. R. Green.
3. Some of the Difficulties of the Present Situation, Dr. A. R. Craig.
4. Remedies Proposed by the Committee, Dr. Thomas McDavitt.

DISCUSSION.

A general discussion of membership regulation was conducted under the following heads:

1. Fiscal Year. Should the fiscal year coincide with the calendar year? Should the fiscal year be the same in all county and State societies?
2. Should membership expire automatically at the end of the calendar year, and a new roster for each county and State society be made with the beginning of each year?
3. When should membership reports from county secretaries to State secretaries be due?
4. Should the dues of new members, joining after the first of the year, be prorated for the remainder of the year?

5. Should an admission fee be required in addition to the annual dues?
6. Should uniform application blanks, receipt blanks, and membership and transfer cards be adopted?
7. Should constituent State associations hold charters from the American Medical Association?
8. Should a uniform plan for the transfer of members be adopted?

In addition to the above Dr. George H. Simmons, editor and general manager, discussed the question of membership in the American Medical Association, and the changes in name proposed by the Board of Trustees.

REPORT OF THE COMMITTEE ON RECOMMENDATIONS.

After two days' discussion it was evident that the secretaries present were agreed as to the advisability of a uniform fiscal year for all parts of the organization, to coincide with the calendar year, and that they favored the expiration of membership at the end of each year and a complete revision of the membership rolls at the beginning of each year. The committee on recommendations, consisting of Dr. E. J. Goodwin, Missouri State Medical Association; Dr. Wilfred Haughey, Michigan State Medical Society; Dr. Perry Bromberg, Tennessee State Medical Association; Dr. William S. Gardner, Medical and Chirurgical Faculty of Maryland, and Dr. F. R. Green, secretary of the committee and of the Council on Health and Public Instruction, brought in a report recommending the adoption of provisions on these two points, and that all other points be deferred for further consideration. The report of the committee follows:

The Committee on Recommendations herewith submits the following report:

1. We recommend that this conference endorse the plan of having the fiscal year coincide with the calendar year in all parts of the organization. We further recommend that secretaries of all State associations which have not already adopted this provision bring this matter to the attention of their associations and recommend its adoption.
2. We recommend that constituent State associations adopt provisions making dues in component societies payable on January 1 of each year, and requiring county secretaries to report to State secretaries all members in good standing, together with their per capita assessment for the current year not later than March 31. State societies desiring to do so may provide a shorter period.
3. The recommendation regarding the third question under discussion is covered by our recommendation of the second.
4. Regarding the prorating of dues, we recommend that this be made optional with each component society.
5. Regarding an admission fee for membership we recommend that this be made optional with component societies.
6. While the committee recognizes, as a general principle, that a uniform system of blanks for county and State societies is desirable, as soon as practi-

cable, we recommend further consideration of this question at a later conference.

7. We recommend that the House of Delegates of the American Medical Association be asked to consider the advisability of issuing charters to constituent State associations.

8. We recognize the desirability and advantage of a uniform method of transfer, but this system cannot be established until there has been developed a greater uniformity in other details of organization. We therefore recommend that this question be made the subject of discussion at a future conference.

9. The committee recognizes the value of this conference to the State association secretaries, and to the purpose of organization; it therefore recommends that future conferences of this character be held.

The report of the committee was unanimously adopted by a rising vote. It was also moved and carried that the secretary be requested to send copies of the report to each State secretary and to each State journal, and that the proceedings of the conference, as published in the *Bulletin*, be furnished to each State secretary desiring them, in sufficient quantities to send one to each member of the State association. After a vote of thanks to the Board of Trustees for making this conference possible by the appropriation, the conference adjourned.

Tyree's Antiseptic Powder.

Tyree's Antiseptic Powder, the false formula of which was disclosed by the Council on Pharmacy and Chemistry six years ago, is now being exploited to the public. In this exploitation much stress is laid on the fact that this preparation has been used by the medical profession for many years. In commenting on the share which the medical profession plays in the evolution of patent medicines, the *Journal A. M. A.* (Aug. 24, 1912, p. 666) says: "When the history of the 'patent medicine' business comes to be written impartially and fairly, it will be realized that we, the medical profession, have been in no small degree responsible for its growth. Not a few widely advertised nostrums owe their commercial success solely to the ill considered use accorded them by physicians, to whom they were first exploited." As a well-known and brilliant advertising man once said:

"The patent medicine of the future is one that will be advertised only to doctors. Some of the most profitable remedies of the present time are of this class. They are called proprietary remedies. The general public never hears of them through the daily press. All their publicity is secured through the medical press, by means of manufacturer's literature, sometimes gotten out in the shape of a medical journal, and through samples to doctors. . . . The medical papers will reap the harvest and the physician himself, always so loud in the denunciation of 'patent medicines,' will be the most impor-

tant medium of advertising at the command of the proprietary manufacturer. In fact, he is that today."

Of the conditions here described probably no better example can be found than Tyree's Antiseptic Powder. For years this preparation was advertised to the medical profession under claims that were fraudulent as to both composition and therapeutic effect.

The case of Tyree's powder should do much to induce physicians to write individual prescriptions suited to the needs of each case rather than to employ promiscuously some proprietary mixture said to be adapted to all cases and therefore bound to go to the public in the end.

Growth in the Use of Bacterins.

Treatment of infectious diseases with preparations derived from corresponding micro-organisms is unquestionably growing in favor. Not only do the bacterial vaccines (or bacterins) seem destined to a permanent place in therapeutics, but their field of applicability is constantly broadening. Proof of this is seen in the growing list of these products announced by Parke, Davis & Co., no less than fifteen of the bacterins now being offered to the profession.

There are a number of reasons for the favor which is being accorded to the bacterial vaccines. In the first place these products are in consonance with the scientific trend of present-day medication. They are being used with a gratifying measure of success. The method in which they are marketed (sterile solutions in hermetically sealed bulbs and in graduated syringes ready for injection) appeals to the modern medical man, assuring, as it does, both safety and convenience. The moderate prices at which they may now be purchased will tend to give them still greater vogue. And these prices are worthy of note, since they represent a great reduction from those formerly prevailing, amounting, if we are not mistaken, to as much as 60 per cent. in many cases. They are announced elsewhere in this journal over the signature of Parke, Davis & Co. and will repay a careful scrutiny.

MEMBERS of the Maine Medical Association attending the Congress of the Surgeons of North America in New York, in November, are cordially invited to inspect the new *Surgeries, etc.*, published by Lea & Febiger, which will be on exhibition during the week in the Ball Room of the Waldorf-Astoria Hotel.

☞ The firm's Maine representative will be at the stand

Medico-Legal Matters.

Abstract of the U. S. Quarantine Regulations, 1910.

Section 1. Quarantinable diseases are cholera, yellow fever, small pox, typhus fever, leprosy and plague.

2. Masters of vessels clearing from any foreign port for a port in the United States must obtain an original bill of health signed by a United States consul or medical officer.

27. Certain food products, viz.: unsalted meats, sausages, dressed poultry, fresh butter, fresh milk and fresh cheese shall not be shipped from districts where cholera prevails. Fresh fruits and vegetables may be shipped if the inspector can certify that they have not been exposed to cholera infection.

29. Steerage passengers and crew coming from cholera infected districts should be detained five days in suitable houses or barracks located where there is no danger from infection, and all baggage inspected and if necessary disinfected.

33. It is advisable that at ports where yellow fever prevails, precautions should be taken to prevent the introduction of mosquitoes (*stegomyia*) on board the vessel, etc.

34. Passengers and crew, who in the opinion of the inspecting officer have been definitely exposed to the infection of yellow fever, should not be allowed to embark for six days after said exposure. Those immune to yellow fever are exempt from this provision.

35. At ports or places where plague prevails, in men or products, every precaution should be taken to prevent rats, fleas or other vermin from getting aboard, etc.

40. Passengers and crew who, in the opinion of the inspecting officer, have been definitely exposed to the infection of plague should not be allowed to embark for seven days after said exposure, unless already immune to plague by recent previous attack, or prophylactic serum, etc.

41. Steerage passengers and crew coming from districts where smallpox prevails in epidemic form, or who have been exposed to smallpox, should be vaccinated before embarkation, unless they show satisfactory evidence of having acquired immunity to smallpox by previous attack, or successful vaccination within one year, and their baggage inspected and if necessary disinfected.

42. Steerage passengers and crew who, in the opinion of the inspection officer, have been exposed to the infection of typhus fever, should not be allowed to embark for a period of at least twelve days

after such exposure and until their baggage has been disinfected and the destruction of vermin assured.

43. No alien who is a leper should be allowed to embark for the United States.

53. At or convenient to the principal ports, quarantine stations should be equipped with all appliances for the inspection and treatment of vessels, their passengers, crews, and cargoes.

55. At a fully equipped quarantine station, there should be adequate provision for boarding and inspection, apparatus for mechanical cleansing of vessels, apparatus for disinfection by steam, by sulphur, by formaldehyde, by disinfecting solutions, or any other methods prescribed in these regulations; also a clinical laboratory, hospitals for contagious and doubtful cases, a steam laundry, detention barracks for suspects, bathing facilities, a crematory, a sufficient supply of good water, and a proper system for the disposal of sewage.

86. The body of no person dead of quarantinable disease other than yellow fever shall be allowed to pass through quarantine until one year has elapsed since death. Such bodies must be transported in hermetically sealed coffins, the outsides of which have been carefully disinfected.

In the case of the bodies of such persons as may have died of quarantinable disease other than yellow fever on the voyage or upon arrival at quarantine, cremation should be resorted to if practicable and consented to; if not, the body should be wrapped without preliminary washing, in a sheet saturated with a solution of bichloride of mercury 1:500 and buried, surrounded by caustic lime.

SPECIAL REGULATIONS ON ACCOUNT OF CHOLERA.

91. If the vessel carry persons from cholera-infected ports or places, a bacteriological examination should be made of any cases of diarrhea to exclude cholera before granting free pratique.

95. The greatest care must be exercised to prevent the spread of the infection through the agency of flies or other insects.

SPECIAL REGULATIONS ON ACCOUNT OF YELLOW FEVER.

103. A vessel aboard which a case of yellow fever has occurred at any time during the voyage shall be treated as follows:

(a) Careful visual and thermometer inspection of all persons.

(b) The sick are to be immediately disembarked, protected by netting against the access of *stegomyia* mosquitoes, and transferred to a place of isolation.

(c) Other persons should be disembarked, if possible, and subjected to an observation of six days, dating from the day of last possible exposure.

(d) Persons under observation presenting an elevation of temperature above thirty-seven and six-tenths C. shall be isolated in a screened apartment.

(e) The ship shall be moored at least two hundred meters from the inhabited shore.

(f) The ship shall be fumigated for the destruction of mosquitoes before the discharge of cargo, if possible. If a fumigation be not possible before the discharge of the cargo, the discharge of cargo shall be under the supervision of the quarantine officer, and may be permitted as follows: by (1) the employment of immune persons for discharging the cargo; or (2) if non-immunes be employed, they shall be kept under observation during the discharging of cargo and for six days to date from the last day of exposure on board.

108. For the destruction of mosquitoes, there shall be a complete and simultaneous fumigation of all parts of the vessel by sulphur dioxide gas, two per cent volume gas, two hours' exposure. Where sulphur is liable to injure articles, pyrethrum powder, camphophenol, or other approved culicide may be used instead.

SPECIAL REGULATIONS ON ACCOUNT OF PLAGUE.

111. Vessels from ports infected with plague, in men or rats, which have docked, or which have not taken precautions necessary to prevent the ingress of rats or vermin, and on which effective measures have not been taken to destroy same under the supervision of an accredited medical officer of the United States, shall, upon arrival, be treated as follows:

(a) Careful inspection.

(b) Fumigation for the destruction of rats.

113. Treatment of vessels without cargo for plague shall be the simultaneous fumigation with sulphur dioxide, not less than two per cent gas, for six hours' exposure.

114. Treatment of vessels with cargo shall be the fumigation with sulphur dioxide, four per cent gas, six to twelve hours' exposure, according to the stowing.

SPECIAL REGULATIONS ON ACCOUNT OF SMALLPOX.

118. On all vessels arriving with smallpox on board, or having had smallpox on board during the voyage, any of the personnel who have been exposed to the infection of the disease must be vaccinated or detained in quarantine not less than fourteen days since last exposure, unless they show satisfactory evidence of successful vaccination within one year, or of having had smallpox.

SPECIAL REGULATIONS ON ACCOUNT OF TYPHUS FEVER.

123. For the purpose of these regulations, twelve days shall be considered as the period of incubation of typhus fever.

SPECIAL REGULATIONS ON ACCOUNT OF LEPROSY.

129. Vessels arriving at quarantine with leprosy on board shall not be granted pratique until the leper and his baggage has been removed from the vessel to the quarantine station.

County News.

CUMBERLAND.

The third quarterly meeting of the Cumberland County Medical Society for 1912, was held at the Congress Square Hotel, on Friday, October 25th. There were present 40 members of the Society and 11 invited guests.

The paper of the evening was read by Dr. Walter M. Boothby of Boston, formerly anaesthetist at the Boston City Hospital and recently appointed to fill that position at the new Peter Bingham Hospital. The subject was "Present Day Methods of Anaesthesia." Dr. Boothby gave a careful presentation of the subject with many new ideas obtained in his investigation. He explained in detail the precautions and dangers in the use of nitrous oxide oxygen anaesthesia and demonstrated his own apparatus for giving nitrous oxide-oxygen combined with ether. He also described anaesthesia by the intra-tracheal method. A chafing dish lunch was enjoyed following the paper.

At the business meeting Dr. Harold J. Everett of Portland was elected County Editor for the Maine Medical Journal.

PHILIP P. THOMPSON, *Secretary*.

PORTLAND MEDICAL CLUB.

The Portland Medical Club and Public Health Education Committee of the A. M. A. were fortunate in having for their speaker, at the public meeting, October 17th, Dr. Henry W. Miller, Superintendent of the State Hospital for the Insane.

His subject, "Eugenics," one of great interest to present day scientists, was most ably presented.

The deplorable increase of undesirable citizens through the marriage of the tubercular, alcoholic, insane and feeble minded individuals was strikingly shown, by carefully prepared charts.

Public and private philanthropy have failed to cope with the mistakes of generations in the making of men—and Dr. Miller believes education of the public is the remedy—and expressed his disapproval of sterilization of the unfit.

We hope other medical societies and the public may have the privilege of hearing this lecture.

L. B. HATCH.

WESTBROOK MEDICAL CLUB.

The first regular meeting of the Westbrook Medical Club will be held at the home of Dr. Ferren, on the first Monday of November. An election of officers for the ensuing year will be held.

F. E. FERREN, *Secretary*.

KENNEBEC.

The Kennebec County Medical Society held its regular meeting Wednesday evening, October 23rd in Waterville. The Banquet was served at the Elmwood Hotel at 6 P. M., and after the business session, Dr. Harry Goodall of Boston, read a very interesting paper on "Diabetes."

Dr. Ralph Marsh of Guilford, President of the Maine Medical Association, was present and spoke on matters pertaining to the State Organization. After the general discussion, the meeting adjourned.

WELLINGTON JOHNSON, *Secretary*.

PISCATAQUIS.

The Piscataquis County Medical Society held its Quarterly Meeting Thursday, October 17th at the Y. M. C. A. Building at Greenville Junction, Maine.

Drs. A. E. Schrivvers and James McFayden of Milo, were admitted to the Society and Drs. Edgar Flint of Foxcroft and Guy Dove of Guilford made application for membership.

Drs. Hunt and Pritham of Greenville gave a very interesting Clinic in the Y. M. C. A. Hospital followed by an instructive talk on "Fractures" by Dr. Hunt. This was one of the most profitable meetings the Society has held and the members should fall into line, and receive the benefit of these good meetings as they are passing.

The laboring men in the vicinity of Moosehead Lake are very fortunate in having the beautiful Y. M. C. A. Building at Greenville Junction, built for their benefit and comfort, by the Hollinsworth and Whitney Company and presented by it to the Y. M. C. A.

The Hospital in connection with the regular Y. M. C. A. Building, with its accommodations and attractions for the laboring man, affords much comfort in time of illness or accident, and fills a long felt want in this section of the State, as it is easily reached from any part of the Lake. The Hospital proper contains operating and sterilizing rooms, eight private rooms for patients, a small ward and several other rooms available when necessity demands. The cases are in charge of Dr. H. Hunt and Dr. F. L. Pritham and it is a pleasure to visit their well regulated and clean, up-to-date little Hospital and see what can be accomplished up in the Moosehead region.

Piscataquis County Society has to thank the Greenville doctors for a very pleasant day at their fine Institution. The ladies were invited to attend the Banquet, and those present were Dr. and Mrs. H. Hunt, Dr. and Mrs. F. L. Pritham, Greenville; Dr. E. D. Merrill and party, Foxcroft; Dr. and Mrs. R. H. Marsh, Dr. J. L. Potter, Guilford; Drs. H. A. Snow, A. E. Schrivvers, and James McFayden, Milo.

R. H. MARSH, *Secretary*.

YORK.

The 70th quarterly session of the York County Medical Society was held in G. A. R. Hall, North Berwick, Thursday, October 10th.

The meeting convened at 11 o'clock, President E. C. Cook of York Village in the chair.

The minutes of the July session at Biddeford Pool were read and approved. Applications for membership from five York County physicians were read and voted to be referred to the Board of Censors.

Dr. J. M. O'Connor read a letter from Dr. R. H. Marsh, Guilford, President of the Maine Medical Association, in regard to questions asked in the letter. First, it was voted, on motion of Dr. L. L. Powell of Saco, that the York County Medical Society is in favor of continuing the State Journal, and that one number of the Journal should be devoted to the publication of the proceedings of the sessions of the Maine Medical Association.

Second, in regard to Defense Fund, it was voted, on motion of Dr. J. A. Randall of Old Orchard, that President Marsh be provided with a copy of the action taken at our April session. It was at that time voted to adopt the Committee's report.

There was a general discussion in regard to making our programs more beneficial and entertaining, enlarging the membership and increasing attendance at the meetings.

It was voted to instruct the Treasurer to pay such bills as were due.

An excellent dinner was served at the North Berwick Hotel, 12.30 to 1.30.

At the afternoon session, Dr. A. C. Heffinger of Portsmouth, N. H., presented a paper, "Subphrenic Abscess," which was illustrated by various charts.

The second paper was by Dr. Francis P. Emerson, Beacon Street, Boston, whose subject was "Chronic Focal Suppuration of the Head with General Systemic Symptoms."

Both papers afforded much pleasure and instruction, and there was a good discussion entered into by all present.

Votes of thanks were extended to Drs. Emerson, Heffinger and McCorison for their services towards the success of the meeting.

Those present: Drs. E. C. Cook, York Village; J. C. McCorison, W. E. Lightle, North Berwick; H. L. Prescott, Kennebunkport; C. E. Lander, Alfred; L. L. Powell, Saco; J. M. O'Connor, F. E. Small, C. F. Traynor, Biddeford; R. S. Gove, C. W. Blagdon, D. W. Wentworth, E. L. Burnham, W. H. Kelly, J. N. L'Heureux, Sanford; B. M. Moulton, L. W. Parady, Springvale; A. C. Heffinger, Portsmouth, N. H.; F. P. Emerson, Boston; J. A. Randall, A. L. Jones, Old Orchard.

ARTHUR L. JONES, *Secretary*.

Book Reviews.

Infant Feeding.

By Clifford G. Grulee, A. M., M. D., Assistant Professor of Pediatrics at Rush Medical College, Attending Pediatrician to Cook County Hospital. Octavo of 295 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$3.00 net.

The thorough newness of this book recommends it. It presents plainly the German point of view in infant feeding.

The classification of nutritial disorders is that of Finkelstein, who divides all such disturbances into four classes, namely: weight disturbance, dyspepsia, decomposition and intoxication. The diagnosis and treatment of these conditions are concisely set forth. As a whole, infant feeding is treated in a simpler manner than has been the rule with text-books. Although this book cannot be accepted as the last word in infant feeding, it offers new help in preventing and curing the nutritional disturbances of infancy.

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Serum and Vaccine Therapy. 606.

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M. C. W.

New and Non-Official Remedies.

(1912,) American Medical Association, Chicago, Ill.

This volume contains the descriptions of the articles which have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association prior to January 1, 1912. This work is issued annually and contains many interesting facts concerning new remedies and refinements of older preparations.

M. C. W.

Acromegaly. A Personal Experience.

By Dr. Leonard Mark, London. Published by Bailliere, Tyn dall & Cox, London, 1912.

This is a delightful book on a rare disease by a physician, who is himself its victim. With the acumen of a skilled practitioner, he describes his life, and elucidates one by one the various symptoms of acromegaly as they crept upon him, known long before by medical friends but unrecognized by himself until he had actually suffered from it for fifteen years. When the truth at last burst upon him, he began an accurate journal of his symptoms, and in the pages of this work we have the life-history of an acromegalist.

The advantages of such a book is that whilst ordinary patients recite their symptoms vaguely, we here find an accurate and chronological list of everything that happened to a physician, and who wrote out all that happened for his own benefit, as well as for that of his medical advisers. The book is furnished with photographs of the writer's personal appearance at various periods of his life, of his jaws and teeth, of his fields of vision, and with skiagraphs of the bones of the skull and extremities. A very full index adds greatly to the value of the book for the consulting physician, for with it in hand, he can at once compare the symptoms here mentioned, with those exhibited by his patient in his office.

One of the most interesting lessons to one who specializes in diseases of the eye and ear is the variations in the refraction of the eyes, or in the tinnitus and hearing of Dr. Mark from time to time. A consulting physician will at once observe these curious facts and is in duty bound to emphasize to his patient something of this sort. "So long as you remain affected with this disease, your sight is liable to change from time to time. Now bear in mind, that if after a while your lenses fail to make your vision clear, it is not blindness which is coming on, nor is it the fault of your expert oculist that your former lenses have become defective, but the fact is, that this disease changes the shape of your eye and the amount of your defect of vision, and consequently you must pay great attention to obtaining accurate alterations with the use of drops as the failure in vision occurs." Remarks of the same tenor will also suggest themselves to the practitioner regarding the tinnitus and the alterations in the hearing.

This remarkably valuable book can be obtained through any importing bookseller, and ought with the duties and postage to cost somewhere in the neighborhood of \$3; money, in my opinion, very well invested, even if acromegaly is a rare disease. J. A. S.

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Address X, Care Medical Journal

PERSONAL NEWS AND NOTES.

The 93rd annual session of the Medical School of Maine, the Medical Department of Bowdoin College, opened October 17th. All of last year's students in the first three years of the course have returned for this year, except those who failed to receive promotion, on account of the requirement for entrance of at least one year of preliminary training in an academic college, this training to include chemistry, physics, biology and either French or German, the present entering class numbers about half as many students as the entering class of last year, which consisted of thirty-five men.

In order that the graduates of the school may satisfy the requirements for practice in the State of New York, the number of "full-time" teachers has been increased to six. The new Edward Mason Dispensary, a gift to the college by Mr. and Mrs. Chisholm, will be ready for occupancy in a few days. All but one or two of the members of the senior class have already completed their clinical work in obstetrics at the Boston Lying-in Hospital.

At the last meeting of the Cumberland County Medical Society, Dr. Harold J. Everett of Portland was elected County Editor for the Maine Medical Journal.

Dr. W. C. Peters of Bangor was in attendance at the Maine State Conference of Charities and Correction held at Saco.

Dr. Percy Somers of Portland is recovering from his accident of a few weeks ago.

Dr. C. L. Cragin of Portland has bought a house on Congress street, which he will occupy after remodelling.

Dr. E. W. Gehring of Portland has resigned his position from the Medical School of Maine.

Dr. F. Y. Gilbert of Portland has returned from a three weeks' vacation up through the Moosehead region.

Dr. W. Bean Moulton of Portland has returned from the meeting of State Secretaries and Editors Association, which was held in Chicago the latter part of October. A full report of this meeting appears in this issue of the Journal.

Carl J. Hedin, M. D., first assistant superintendent of the Maine Hospital for the Insane at Augusta, has been appointed superintendent of the State Home for the Feeble Minded at Pownal, to succeed Dr. George S. Bliss, whose resignation takes effect November 15, 1912.

On Friday, October 11th, Gov. Plaisted nominated Dr. Eugene D. O'Neill of Biddeford for coroner.

Dr. Sumner B. Marshall of Alfred has recently joined the increasing number of York County physicians who own automobiles. His car is an Overland.

Dr. L. L. Powell of Saco has recently purchased the Geo. F. Patterson home on Temple street in that city, and has been engaged

in carrying out extensive repairs. A fine fireplace has been built, a new bathroom has been fitted up and lighting and heating systems instituted. The doctor has a fine large garden and intends to give a good deal of attention to this part of the place. He moved into his new home the first of October.

Major Clarence F. Kendall of Biddeford left September 26th for Portland, where he met Dr. E. M. Fuller of Bath, surgeon-general of the State, and Major B. B. Bradbury of Norway, with whom he attended the International Congress on Hygiene and Demography held in Washington that week. Later


the three went to Baltimore where they attended the Twenty-first Annual Meeting of the Military Surgeons of the United States, held in that city, October 1 to October 4.

Dr. Guy E. Dove, a graduate of Vermont University, 1911, has recently settled in Guilford, occupying the residence and office of the late Dr. Wm. Cowie.

Dr. and Mrs. D. W. Hayes of Brownville Jct., are in New York, where the doctor is taking a post-graduate course.

Dr. W. R. L. Hathaway of Milo is recovering from an attack of typhoid fever and will soon be able to resume his practice.

Dr. D. L. Harden of Brownville has recently returned from the Mt. Katahdin region, where he has been recuperating after an attack of typhoid fever.



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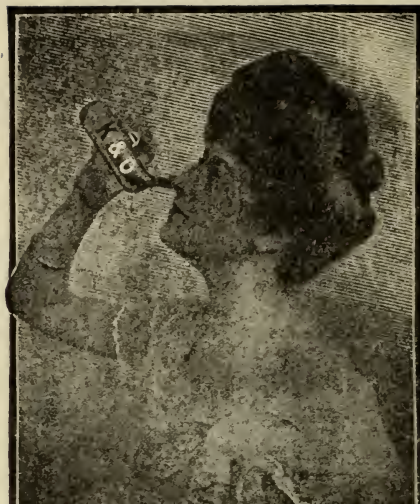
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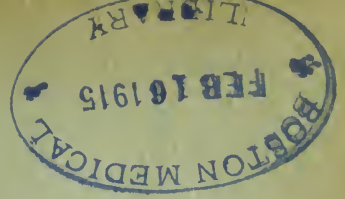


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Official Organ of the State and County Medical Societies.

III, No. 5

DEC., 1912.

\$2.00 per year

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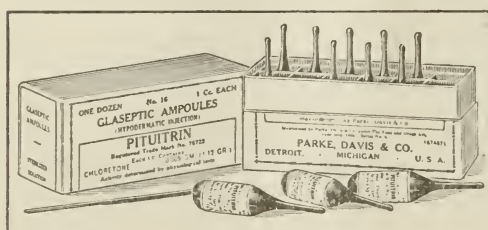
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VOL. III.

DEC., 1912.

No. 5

The Sixtieth Annual Meeting

OF THE

MAINE MEDICAL ASSOCIATION

HELD IN THE
Council Chamber, City Building, Portland, Me.

WEDNESDAY AND THURSDAY,
JUNE 12th and 13th, 1912.

Meeting of the House of Delegates.

Wednesday, June 12th, 1912, 9 o'clock, A. M.

The meeting was called to order by the President, Dr. Stanley P. Warren, at the appointed time.

The President then called attention to the fact that the reading of the minutes had generally been dispensed with, inasmuch as they were published in the transactions of the business of the meetings, and suggested that it would be in order to make a motion to omit their reading. Such motion being duly made and seconded, it was unanimously voted that the reading of said minutes be omitted.

The next business to come before the meeting was the reports of the Councilors from the various districts.

These reports were only partially made as many of the Councilors had not arrived and were unable to attend until the arrival of various trains from distant points in the State.

Dr. R. W. Wakefield of Bar Harbor, for the Fifth District, Washington and Hancock counties, made the following report:

Bar Harbor, Maine, June 10th, 1912.

Mr. President, Fellow Councilors and Delegates:

As your Councilor of the Fifth District, I herewith submit the following report:

Three successful meetings have been held in Washington County during the year. Judging from the excellent meeting I attended at Eastport in May, am quite sure the Washington County Medical Society is in a happy and prosperous condition. A small gain in membership has been made and I am especially glad to note the harmony and spirit of good fellowship among the members.

The State Association need not be concerned about the future of the Washington County Society.

According to the amended by-laws, the Hancock County Medical Society has held six successful meetings during the year instead of one each month as formerly. This seems to have been a wise change, since the meetings have been better attended and we have made up in quality what we have lacked in quantity.

A few members have been lost by removal from the county, but new ones have been added, so that the membership remains about the same.

The same harmony exists among the members in Hancock as in Washington County and, on the whole, I feel that the Hancock County is in better shape than last year.

There is one feature which applies to both counties that is unfortunate, namely, that the societies are not more truly representative of the whole county.

In Washington County, it is almost useless to hold meetings except in the extreme eastern part, the men in the western and central parts taking but indifferent interest.

In Hancock it is practically useless to attempt to hold meetings outside of Mount Desert Island for the same reason. To be sure, the men in both counties are widely scattered, but I do think that the distant members could take more interest in their county society and make greater effort to attend the meetings.

R. W. WAKEFIELD.

Dr. G. B. Swasey of Portland, for the First District, Cumberland and York Counties, reported as follows:

To the House of Delegates:

It is with satisfaction that I make my report as Councilor for the First District, for the year 1911-1912.

At present the membership of the Cumberland County Medical Society is one hundred and fifty-two. This is a decided gain over any previous year. While membership in a County Society is now requisite in order to obtain membership in the State Society, especially with new men, I find that this fact does not fully account for the increased membership and efficiency of this Society.

Its present status is due in large measure to the efficient management of its officers.

Special efforts have been made to obtain papers of a high order at the meetings of the Society, and these have been presented by eminent men from leading medical centers. These efforts have been appreciated and the meetings have been fully attended. We are happy to believe that our Cumberland Society is as strong as any in the State.

It is also with satisfaction that I report regarding the York County Society. The membership of this society has increased until it is now fifty-five and there is hope that the coming year will further increase the membership, together with the enthusiasm and efficiency. It was my full purpose to attend the annual meeting of the Society but I was unable to do so. During the past year the Society has held its meetings at different localities throughout the county, and this is believed to have increased the interest and the growth of the Society. It is hoped that this custom will be fully carried out for the coming year.

Respectfully submitted,

GEO. B. SWASEY, *Councilor 1st Dist.*

The Secretary read a letter from Dr. George H. Coombs, Councilor for the Third District, Sagadahoc, Knox and Lincoln Counties, as follows:

The Sagadahoc and Knox County Societies, while small, are doing good work, with a gradually increasing membership, while all the members take a great deal of interest in the meetings.

G. H. COOMBS, *Councilor 3rd Dist.*

Dr. R. H. Marsh of Guilford, Councilor for the Sixth District, Aroostook, Penobscot and Piscataquis Counties, reported as follows:
Mr. President, Fellow Councilors and Delegates:

I have not had the pleasure of visiting the Aroostook County Society, which is in my district, this year, but I have attended several meetings of the Penobscot County Society, and have always found them to have a very interesting program prepared and their meetings are always well worth attending. Penobscot County being one of the largest in the State and having one of the largest and oldest societies, has always contributed to the profession some very good papers, not only from local talent, but they have always been fortunate in getting good articles from Boston and other points outside their own County Society. This Society is certainly in a very flourishing condition and it is unnecessary to give a more extended report of the work at this time.

Piscataquis County has a very small Society—perhaps the towns being somewhat remote from each other—the county in some portions being very sparsely populated or settled, it is not easy to create great enthusiasm among the physicians. That Society has held but four meetings this year, and I think from the number of members of the Society present, they have had very good meetings. The membership is only twenty-four, I believe, in round numbers, and they have had an average attendance of about fourteen. We do not consider that the Piscataquis County Society is in a specially flourishing condition, but considering the distance that many of the members have to drive to attend the meetings, this is perhaps not to be wondered at. I will give a written report of this later if it is required.

The reports of the several Councilors were accepted and ordered made a part of the record.

PRESIDENT WARREN—The next business to come before the meeting is the matter of fixing the time and place for holding the next annual meeting. Where will the next meeting be held, gentlemen?

DR. PETERS—I should like to express my opinion regarding that

matter. I believe that we should hold our next meeting in Portland. We have the largest gatherings in Portland, and we have the greatest amount of interest it seems to me; of course we should occasionally visit some other portion of the State — go down to Bangor or to some point in the western part of the State, in order to meet the people there and let them see that we do not always meet in Portland, but I think we will agree that our annual meetings in Portland are always successful and satisfactory meetings. I would move that the next annual meeting be held in Portland. We have journeyed about the State a good deal, to Bar Harbor, Augusta, Lewiston and so on, and have held but one meeting in Portland for four years.

DR. HILL — I would like to say a word in favor of holding the next annual meeting in Portland. I think it is a great mistake to go about to the distant portions of the State. We can come here no matter in how great numbers and have a good comfortable time and good accommodations, and Portland is easy to reach from all parts of the State. I do not object to going occasionally to other places, to Bangor, or wherever it is thought best, where we can obtain good accommodations and where the place is easy of access, but I do object to going to Lewiston, Bar Harbor and Waterville, where we cannot have the accommodations which we can have here. We have never had such good attendance in any place we have visited as we have right here in Portland. I second the motion of Dr. Peters that our next annual meeting be held in Portland.

DR. MOULTON — I would suggest that the time for holding the meeting be the week following the meeting of the American Medical Association.

PRESIDENT WARREN — It has been moved and seconded that the next meeting of the Maine Medical Association be held at Portland, the second week in June. Are you ready for the question?

SECRETARY MOULTON — The motion is that the meeting shall be held in Portland the week following the meeting of the American Medical Association.

PRESIDENT WARREN — That is the first week in June, is it not? Are you ready for the question? It has been moved and seconded that the next meeting of this Association be held at Portland, the week following the meeting of the American Medical Association. Those in favor say "Aye." Contrary minded, "No."

It was voted to hold the next meeting in Portland the week following the meeting of the American Medical Association.

PRESIDENT — What is the next matter to come before us, Mr. Secretary?

SECRETARY — Dr. G. R. Campbell, the Councilor for the Fourth District, Kennebec, Somerset and Waldo Counties has arrived, and has a report to make.

DR. CAMPBELL — I was here at nine o'clock, Mr. President, but was unable to come in until just now.

I have the pleasure to report for Kennebec, Somerset and Waldo Counties as follows:

Somerset County has lost three from its membership during the past year, one to Franklin County, one to Piscataquis County, and one man has withdrawn from the Society on account of age, and there was one member dropped on account of irregularity of practise. They have only held two meetings the past year, I believe. I visited them at North Anson and had a very pleasant visit and they had an interesting meeting.

Waldo County Society has fifteen active members and they have held four meetings the past year. The last meeting I attended was held at Belfast, last Monday, June 10th. We had a paper by Dr. Lincoln of Augusta which was very interesting and instructive, and there were twelve members of the Society present.

The Waldo County Society was one which I had the pleasure of helping to form and they have done very well considering the large area over which the members are scattered.

Kennebec County has, I believe, fifty-six members in good standing. They have held four meetings during the past year, all of which have been very well attended, and I considered them very interesting meetings.

PRESIDENT — Any other reports to be made at this time? If not, what is the next business to come before the meeting?

DR. CAMPBELL — There is one matter which is to be considered here, perhaps it should not come up at this time, but should come under the head of some other business. It is in regard to what can be done in the case of a man who has had his license revoked by the State Board, still continues to practice and use the title. Whether the county attorney has a right to prosecute him after he has been given a license and that license has been taken away from him. When the license has been taken away there is no reason why he should continue to use the title of doctor.

PRESIDENT — In regard to matters of that kind we have to be very careful. Some time ago, I happened to be one of the censors of Cumberland County Medical Society and we undertook to discipline a man who undoubtedly warranted this action. His name was to be brought before our meeting and some action taken. He upon learning this, immediately took legal action and notified the Board of Censors he should immediately have an injunction and the terrors of the law would be spread over the Board of Censors. Now in cases of this kind where lawsuits are likely to develop, will the County Society stand by the Board of Censors and pay the bills incurred by them in matters of this kind? In taking up a question of this kind, we must be prepared to fight legally, and that is likely to be a pretty expensive proceeding. Anybody else anything to say on this matter?

DR. CAMPBELL — I am told that a certain man in Belfast who had gained his license under the old rules of practise years ago, and who had practised for a number of years — he is not a graduate of any school — and part of the time he practises as a physician and part of the time as an oculist or optician — he is not a registered practitioner, but he poses first as a doctor and then as an optician — the fact is as I have said he is not anything in particular, is not a graduate of any school of medicine or anything else, and the State Board became aware of what he was doing and revoked his license, but he still continues to use the title of doctor and all the privileges to be derived from it in spite of the license having been revoked. The county attorney has been appealed to and he said that because the Board of Examiners had given that man a piece of paper authorizing him to do certain things and then had voted to take that piece of paper away from him, that that does not constitute any action for which he could prosecute him and so we have been unable to get the county attorney to do anything and the man in the meantime continues to do as he chooses about practising. Now the question is can the county attorney prevent this if he wishes to do so? Has he a right to prosecute the man?

DR. PETERS — I move that this question be submitted to the Committee on Legislation, and I think it would be well for them to look into the matter carefully and report back to the House of Delegates.

The motion was unanimously carried.

SECRETARY MOULTON — We have had a great deal of trouble in getting delegates to go to the different State conventions and it is hard to get men to go. Last year, this matter was left to the President with power to appoint. It is a hopeless task to choose delegates at this time, it seems to me, to attend the Society meetings in Vermont, New Hampshire and Connecticut. There may be some men in the State who would really like to go but we do not know of them and we have no way of finding out. We put a little item in the Journal saying that anybody who would like to attend the various conventions might apply to the President and he would appoint them as delegates in so far as he was able, but we did not get any applications in this way last year. If there are men who would like to go to New Hampshire to their convention, they might just as well be sent as a delegate, as to appoint some one who does not wish to go and who perhaps may be unable to arrange to go. It seems to me that the only way to do is, if we publish the Journal another year, is to try it once more — put in a little notice saying that anybody who desires to be a delegate can make application to the President. There is no sense appointing men to go to each Society meeting and then get no report of the meeting at all

because they did not want to go, and perhaps did not go, or if they did go took no interest in the matter. Most of them don't go — perhaps cannot leave their work at the time, and if we knew which ones of our members would like to go and would be glad to bring us back an interesting report of the meeting, it would simplify matters a great deal.

PRESIDENT — As the Secretary says it is a pretty difficult job to pick out men as delegates to the different societies with the idea that they are going to report to this Association. Has any one else anything to offer on this matter?

SECRETARY — My suggestion would be that invitations be printed in the transactions which are published in the Journal, for the members who would be glad to attend any of the different State Society meetings, to consult with the President, and then give the President power to appoint such men as he sees fit. If the appointment is left to the President's discretion, he can do as he sees fit about appointing any one who may apply.

DR. HILL — It seems to me that would be the most sensible and successful solution of the matter. I make the motion that the matter of appointing delegates to attend the various State Societies be left to the President with power to act.

The motion was seconded and unanimously carried.

PRESIDENT — What is the next business to come before the meeting?

SECRETARY — One thing I might speak of is this: there is a great deal of work to be attended to tomorrow — it is going to be a rather busy day. The officers, I believe, are always elected the second day. We have to elect two councilors this year, one for the first and one for the second district. The councilors are elected for three years and the terms of Dr. Swasey and Dr. Bartlett expire this year. We can elect from the floor or this matter can be put off until tomorrow. There are so few here this morning, I think it might be better to have a larger representation present before electing officers. There is nobody here from the Second District, and we have to elect a councilor for that District to take the place of Dr. Bartlett, whose term expires this year, and also a man for the First District.

PRESIDENT — Is there any other member or Councilor present who has a report to make now?

DR. PETERS — I have just been informed that Dr. Gilbert would be here at half past ten and would be ready to report the work of the Journal, and there is also the reports of all the different committees. I should suppose that we had better hear all these reports this morning as they may require a good deal of discussion and time and perhaps considerable explanation.

DR. WAKEFIELD — I was talking with Dr. Bennett, the delegate to the American Medical Association, and he informs me that no alternate has been appointed to the American Medical Association, and that there should be. Another thing, it has not been the custom of the delegate to report to the Council, but he has a report to make which he will make at any convenient time.

PRESIDENT — I am glad to hear Dr. Bennett has a report to make. I think he is right, we have always had a delegate to the American Association but we have not had an alternate. If the delegate has not reported to the Council, he has been remiss in his duty. There is no use appointing these different committees and delegates if they are not going to report back to us. That is what they are appointed for to bring us the report of the various matters that are taking place.

If there is nothing further to be said on this subject, I would like to say a word in regard to the President visiting the different County Societies. The President of this Association is usually a busy man. He is glad to have the privilege of meeting his brother physicians and the privilege of traveling over the State of Maine. But it takes a lot of time to do that work and time with most of us does not hang heavily on our hands. I had the pleasure of going up to Houlton to visit the Association there and it took two nights and one day. I had to use a night and a day to go to Machias and then returning it took the same amount of time—two or three days out of my work. Often we have engagements which make it utterly impossible for us to get away for such a length of time. Now it seems to me that instead of having that work all on the shoulders of the President of this Association, we had better have it divided up into sections and have several of our members to attend to it. If we had a visiting committee appointed consisting not only of the President but other members of the Board of Directors, House of Delegates, Councilors—perhaps a committee of three, and let them take turns in going about meeting the different societies in the State and perhaps meeting with them more than once in the year, I am sure it would help very materially.

There is no question but that the County Societies appreciate the visits of the President. They are all glad to see the presiding officer of the State Association—it seems to wake them up and perhaps creates some new enthusiasm, but it seems to me that if we had some one to help the President out with these visits that it might be worth while — perhaps let the Vice Presidents share in the work.

I am offering this merely as a suggestion. I have no axe to grind, but I think something might be done on that matter to help out the President, and I wish you would think it over and sometime in the course of our meetings I will call it up again.

DR. SYLVESTER — It appears to me by looking at the program, we have at the head of the official list, a President and two Vice Presidents. The second Vice President is simply an honorary officer, and it seems to me that this official visiting might well be divided between the President and the two Vice Presidents. These officers are usually selected from various parts of the State, as for instance the First Vice President is from Bangor and the Second Vice President from Waterville, and these men could visit certain portions of the State more conveniently than others and with much less expense than any new official could do. Would it not be better for us to use the President and the two Vice Presidents for this work rather than to create any new officials or expecting the President to visit every County Society in the State.

PRESIDENT — Those are very sensible suggestions, Dr. Sylvester.

DR. PETERS — Does the President have to visit every County Society?

PRESIDENT — I understand he is expected to do so.

DR. PETERS — I see we have a visiting committee whose duties absolutely oblige them to visit County Societies. I don't know as I see the necessity of having another committee of three appointed. The Councilors are supposed to visit their own County Society, are they not?

PRESIDENT — It is not a suggestion that a committee be appointed to represent the President. You see the point is that as things are at present, the Association makes the President do that work and he can not do it without encroaching too heavily upon his time.

DR. PETERS — It occurred to me to leave it optional with the President to visit the societies and have his expenses paid in so far as he is able to do so. As far as encouraging or bracing up these County Societies goes, why are not these six Councilors engaged in just that business, and are their expenses paid?

SECRETARY — I think they are.

DR. PETERS — My point is this: Of course it may be a good thing to have another committee of three appointed to go around and help attend to this visiting, but what should we gain by it. Why is it necessary to have another committee of three appointed when you already have a committee to attend to the visiting.

PRESIDENT — I think Dr. Peters' point is very well taken. We ought not to need another set of officials to do the same work that one of our committees is expected to do. My purpose is to arrange the matter so that the President shall not have so much of this work to do.

DR. SYLVESTER — We ought not to need another set of visitors, it seems to me, to meet the demands of which our President speaks.

If it is made optional with the President to delegate some of this work to the Vice Presidents that ought to take care of a good deal of the work that the President cannot find time to attend to. I suppose there would be no objection to the Vice Presidents doing this work at the suggestion of the President.

PRESIDENT—There is another matter that came up before the House of Delegates last year that I wish to speak about. I am probably repeating something you will hear later, but to explain my point, I will say, I wrote last July, to every State Society we have in the United States, asking them for any points, items or matters of interest in their programs in the State Association meetings, that seemed to make the meetings more popular, interesting and attractive. I received letters from every State Society in the United States and there was not a single one that contained a new idea in regard to making the State Association meetings more attractive. Most of them depending on passing bills, regular business of the meetings or entertainments or something of that kind to keep the members interested. There was nothing scientific whatever that was added for the purpose of making the meetings attractive. To my great surprise, I got absolutely nothing to help me except the knowledge gained by reading the reports and learning that they had experienced quite an increase in attendance since they had divided their work among various sections. Two years ago that question was brought up before the House of Delegates and was turned down. I still think it would be a good idea if the State Association of Maine had its meetings divided among sections, giving a section perhaps to the medical branch, another to surgery, one to the ear and eye, and so on, as the circumstances seemed to point out to us as we progressed. Then the man who comes here and is not specially interested in medical work but is interested in the eye and ear, throat and nose, or any other one branch, can go where he pleases and where he feels that he can obtain the greatest amount of new knowledge, later coming into the general assembly, but he could get in the section in which he was interested, much that he could not get in the general assembly because there is not time for all branches to be taken up as thoroughly as they be discussed in a section. It is the trend of Association work at present to do away with the local papers. Quite a number of the large Societies—State Associations, do not have any local papers at all. Their papers come entirely from a distance. Many of the societies have only single day meetings—only one day in which to complete all their work, and these meetings are addressed by only one man who is usually an outsider. Massachusetts has but one day and has but one speaker who makes an address that they are all glad to listen to. We used to have three days and

now we have gotten down to two days for our meetings. The Secretary of the Massachusetts Association wrote me a nice letter which I would like to read to you but I have mislaid it. He spoke of the papers in the last year's Association meetings, and said they were fine papers, but who, in the general meeting of the Association cares a straw about some technical paper on cardiac irregularity or something of that kind, whatever might be the name of the paper, he asked. These papers are undoubtedly well written and instructive, good papers for the practitioner who is working along similar lines, but not attractive to the general members of the profession. That is so. The paper he referred to I happened to remember and there was not more than half a dozen men who heard it who were specially interested in that theme. What is the use for us to spend a lot of time preparing a paper of this kind and then have to read it to half a dozen men who don't care anything about hearing it and are all the while talking about something else.

I wish you would think the matter of dividing our meetings into sections over very carefully. Our Association is growing; we have got nearly seven hundred members, and we ought to have a meeting here today of four hundred men. We don't have anything like that. If we had, we should have three meetings going on at the same time.

DR. HILL — I am sorry Dr. Bowers is not here, because he would help to support me and I expected he would be present.

At the meeting of the Maine Eye and Ear Association last evening, we voted unanimously to ask this body of delegates to incorporate a section for the eye, ear, nose and throat. This has been brought up in some of our past discussions of the matter and has been denied us by the Association and we felt that the petition was turned down because of the opposition of one or two men. I feel today that that opposition is not here. I have talked with quite a number of the delegates and most of them seemed to favor the matter of our having a section, at this time, which might be devoted to the eye, ear, throat and nose.

It seems to me it would be an advantage to both organizations and that it would help to increase the membership very materially in the Maine Medical Association. I have no doubt of this and it would certainly make our Association more efficient. At present, we have three meetings, one at this time and two others during the year. We have moved from one section to another, and whether the meeting is at Portland, Bangor or Lewiston, we cannot get a satisfactory number to attend. There is always five or six or eight or ten and no matter how instructive are the papers, the men are not there to profit by them. We believe if we can have a section in the Maine Medical

Association once a year, we could then have a full attendance. There would be none of the cliques that we find in the small organizations. Last evening, Dr. Bowers and myself decided to bring this before this Association and ask that our Association which has at the present time twenty-six members, be given a section in the Maine Medical Association. I hope you will agree with us that it would be helpful to you as well as to us, if a section be formed. I would say here that there will not be any extra dues or expense at all. We would have dues of our own to take care of our extra meetings.

PRESIDENT—I am going to ask if the members of your Association are members of this Association.

DR. HILL—I am unable to state as to that, Mr. President, but of course anybody who was not a member of this Association would have to be eliminated. If he is not eligible of course he could not come into these meetings. We would look that matter up very carefully.

DR. PETERS—Of course this matter is coming up in line with the remarks of the President a few moments ago in regard to the meetings being divided into sections in the Association. I wish it might be referred to the general meeting in order that we might hear the discussion from the floor in regard to this matter.

DR. HILL—I would like to have an expression to the delegates here before we go into the general assembly.

DR. MARSH—I think it would be well to leave this matter for discussion in the general assembly. Would it not mean that our meetings would soon be cut up into too many different sections?

DR. HILL—I don't wish to seem persistent, Mr. President, but we have twenty-six members who are interested in this matter. I think if we were given a section for the ear, eye, nose and throat, it might be the entering wedge for other sections to be formed, others might follow and form other sections if we got started. It might be an opportunity for others to get together and get up some new enthusiasm, and I did hope to be able to get a recommendation for a section from this House of Delegates.

DR. PETERS—I suppose that anything that relates to the same business may be considered provided it is done properly. I will make an amendment to my motion that the matter go before the general meeting and state it this way: That the House of Delegates send a communication to the Society to this effect, that they strongly recommend that a section be formed for the eye, ear, nose and throat, and that they also recommend that the program committee of next year be allowed to consider whether or not to form a section for medicine and surgery; that they recommend that the program be divided. First, that this Board of Delegates recommend that sections be established—

one section for the ear, eye, nose and throat, and that they also recommend that the program committee for next year be allowed to divide the meetings into two sections, one for medicine and one for surgery. This to be an experiment.

DR. HILL — I accept the amendment, Mr. President.

DR. MARSH — Where does this stop, if we begin in this way by dividing our Association meetings into sections. One branch of medicine will want a section and another will claim a section, and surgery will come in for its share. Some one will want a section for obstetrics and we shall be all cut up into sections it seems to me. Every branch will want a section and if we let one have a section we must let the others. I should hardly know where to expect the matter to stop.

DR. HILL — We have a good many men interested in the ear, eye, throat and nose—something over forty, I should say, and a great many of them are not personally interested on the other matters relating to the general assembly meetings. We feel that we would like to see these men at these meetings, and if we had a section for our particular work, we think this would bring them to our meetings. I believe you can have an increase of twenty-five or thirty members as easily as not, and I think this would add to the interest of your meetings, for once here they would stay and attend the rest of the meetings. It was proposed by some of our members that we could have our meetings early in the morning of the first day. This would not interfere with the general exercises of the Association and would certainly increase the general interest to quite an extent it seems to me.

DR. MARSH — Provided we divided this Association up into different sections each man would attend the section that was devoted to his own private work. He would come here for that purpose and when that meeting was over, he would be for taking the next train out of town. They would stay just long enough to hear the matters in which they were interested discussed; they would not remain through the rest of the sessions of the Association. It seems to me that by dividing the meeting up into sections, we are pretty likely to lose a good many of the meetings of the real Maine Medical Association. As it is now, we group together all the different branches and bind them into one joint meeting whereby we may all get great benefit from the Association. When we come to have a branch for medicine, one for surgery, one for the ear and eye, one for obstetrics, and so on and so forth as far as it seems to me we shall be called upon to go, there will not be that general interest in the Association as a whole. The man interested in medicine will attend his section and the man interested in obstetrics won't care specially for anything save his line, and the country practitioner who comes here hoping to get help along

all the different lines he must practise daily, will be disappointed. However, I am perfectly willing to leave this to the general meeting to decide, but that is the way it looks to me now.

DR. HILL — It seems to me it would be better to get some of these men to come here and attend the meetings of the sections in which they are interested rather than not to have them come at all. I think the reason that a good many of our practitioners—myself included—have not been here much is that in looking over the program for the meetings there would seem to be very little that would interest me much personally and so I would not make the effort to come. For that reason, I am heartily in favor of dividing the Society into sections. It seems to me perfectly feasible. If we can interest the various members of the profession throughout the State more by dividing our meetings up somewhat and giving to each a chance to hear what is the newest in the branch in which he is interested, I believe we ought to do it. I am heartily in favor of dividing our meetings into sections and I believe it will be for the best interest of the Association to do so.

DR. CAMPBELL — It seems to me the majority of ear, eye, nose and throat practitioners are not doing general work, and therefore I can see the wisdom of having a section for these people—the ear, eye, nose and throat people—but I don't see the wisdom of going further, and dividing the Association up into sections for surgery, medicine, obstetrics and all the other departments of medicine and healing. There are a great many of our members throughout the State who are engaged in all branches of medical work, while in the large cities one man does but one thing, and while I am in favor of granting a section to the ear, eye, nose and throat people, I should want it to stop there.

DR. MARSH — Mr. President, I fail to see how you could stop it there. If you begin granting sections, it looks to me as though you have got to go on and keep it up. If you establish a section for the ear, eye, nose and throat, the surgeons are entitled to their section, the medical men to their section, and so on until you have run through all the specialties.

DR. PETERS — It seems to me we could have a much more interesting program by having the work divided into sections and then having a specialist on each particular theme—some of our greatest people if possible. Lots of us are not interested in all the matters discussed on our programs, and if we had the Association divided up into sections, we might have something that would appeal to everybody and be instructive to all of us. It seems to me we should devote a section to medicine, one to surgery and then have a section on the specialties as well as a section for the ear, eye, nose and throat. In this way

there are several meetings going on at the same time and we should be able to keep up the interest much better. It seems to me it would be a mistake to specify any one particular branch of our profession as being entitled to a section while the others should not be allowed a like privilege.

DR. SYLVESTER — I would like to say as a general practitioner that I think Dr. Peters was very conservative, that is, in having a section for medicine, a section for surgery and a section comprising several specialties. This grouping of the three ought to add to the interest of our meetings and it would make the matter optional with our members and they could attend whatever meetings appealed to them as most interesting and instructive. If these meetings were held in the morning, it would leave us the afternoon free to attend the general assembly meetings as a single body.

DR. HILL — I don't want to take up all the time, but I do feel that twenty-six strong members, as we have represented in the ear, eye, nose and throat Association, and which will be increased to forty in a short time, ought to be granted this request, and I hope the delegates will support me when the matter is taken up later.

PRESIDENT — Is there anything further on Dr. Peters' motion? There being no further discussion, the motion was carried.

Dr. Gilbert then read the report of the work of the Journal of the Maine Medical Association, which report was accepted and ordered placed on file.

The following report covers eleven issues of the Journal beginning August, 1911.

Owing to the June meeting of that year being held so late and no provisions made previous to the meeting for continuing the Journal, it was impossible to get out a July number. The eleven issues of the Journal have represented five hundred and eighteen pages of reading matter, including transactions and papers of the State Association, together with papers read before the County Societies, personal news and notes, Journal Reviews, Book Notices, etc.

The Editorial Staff, together with the majority of County Editors, have shown marked interest in this work and it is largely due to their co-operation that the Journal continues to live. In order to bring it up to a standard in which we can all take a pride, not only the Editorial Staff but every member of the State Association should take an active interest in the work.

During the past year, the work carried on under the heading of Committee Report was made possible through the Journal and this represents the possibilities and scope of a work of this kind. This year we received the balance of the funds from the Treasurer of the Maine Academy of Medicine and Science amounting to \$265.90, which was turned in to the General Treasurer for joint use of the Library and Journal.

In August, 1911, in accordance with the vote passed at the State meeting, the Maine Academy Library was taken over by the Maine Medical Association

and reopened to the medical profession of the State. This library is placed on a circulating basis while the Journal Stenographer is in the room afternoons and a part of the mornings. The books have been re-arranged, indexed and cross indexed, while the Journal has added twenty-eight new books during the current year, together with all the State and some few of the leading independent Journals, all State Board of Health Reports and all Government Reports relative to medicine, also the bulletins of the various Medical Schools.

Through the aid of the Journal, the Maine Medical Association now owns nearly fifteen hundred volumes of reference work with a conservative valuation of eight hundred to one thousand dollars while each year will see fifty or more new volumes added, together with donations from private libraries.

The receipts from July 1, 1911 to April 28, 1912 amounted to \$1,793.96, while the expenditures amounted to \$1,405.41, leaving a cash balance of \$388.55.

Through the courtesy of the authors of various papers, we have been able to assist some few County Societies in arranging their programmes. At times during the year, we have had some eight papers on hand, covering a variety of subjects from which to select, while on the other hand, we had the assurance of the authors that they would accept an invitation to go into any of the counties and re-read the papers. It has also made it easier in arranging the programme for the annual session of the Maine Medical Association.

There has been some little difficulty occasioned in securing the proper change of address of members or in obtaining the proper revised list of members from the county during the year. The Journal's mailing list is taken from the list of the Secretary of the State Association which in turn is made from the lists sent in by the various Secretaries so that the failure of the Secretaries to notify either the Journal or State Secretary of any change of address or location would necessarily result in the Journal going to the old address. The mailing list is made up new each year from the revised lists sent in previous to the June meeting. This matter is wholly in the hands of the Journal stenographer and any errors will be gladly adjusted.

I wish to express my appreciation to the members of the Editorial Staff and the members of the State Association for the co-operation of the work, and think due credit should be given to one and all.

Respectfully submitted,

FRANK Y. GILBERT, *Editor.*

DR. CRANE — In our Society at Bangor, we voted to instruct our delegates to discontinue the Journal. A great many of our members have never received any copies of it. Personally, I received the first two copies, but never received any other copies until I got the March, April, May and June numbers about the 26th of last month, I think it was. That was after some of us had made some objections to continuing the Journal another year because we failed to see any value in it. I don't think we have received enough benefit from it to warrant continuing it another year even though it shows a balance of profit this last year. We get very little from it that is new; we get copies of papers that have been read which we have either heard or read in

some other form, and it seems to me a waste of time and money to continue the Journal, and we are instructed to vote against it.

DR. GILBERT — In regard to the report of the Bangor man, I would say we take our mailing list from the report of our Secretary which is sent to me; it is made up by the official stenographer and is surely made impartially — there could not be any feeling about it. The lists sent in from the counties do not include the names of the members who have not paid their dues, and they don't get the Journal. That was made clear to everybody. It was supposed to be one of the inducements to pay the dues promptly and keep them paid. If there was a failure to pay the dues during the year, those members would not receive the Journal, but if the dues have been paid and the County Secretary has failed to report the matter to us, the County Secretary is to blame and not the Journal. We have kept the mailing list as carefully as possible and have sent the Journal to all the members of the Association whose dues were reported paid, or have intended to do so.

DR. CRANE — I sent out notice of the dues for the year and know that many of them were paid. Never since I have been a member, seven years, have my dues remained unpaid. They have always been paid the first thing because I am Treasurer and I always keep my dues paid as early as they are assessed, and I have never received a copy of the Journal other than as I have told you — the first two numbers and then these last ones all at the same time, after we had complained about the way the matter was being handled.

DR. HILL — I admit that this Journal is not an ideal publication at present; it would be strange if it should be in two years. There are doubtless many ways in which improvements could be made. I felt yesterday decidedly dissatisfied with the Journal and that I should oppose its further publication. But I have been enlightened since I came here and I am satisfied it would be a wrong thing — a step backward as it were, to discontinue its publication after only two years trial. I do not wonder that the Penobscot Society is sore and objects to the way they have been used the past year, but I feel that things are going to be a good deal better. The errors will cease to occur and things will run along much more smoothly, and I shall vote that we continue the Journal another year, hoping that it will prove a great deal more satisfactory.

DR. CRANE — I should like to say this is not a personal matter at all between Dr. Gilbert and me or any other men. It is something entirely impersonal and I am simply speaking for our Society.

SECRETARY — I want to call your attention to Section 5 of Chapter 7 of the By-Laws. It seems to me that all the authority that the

House of Delegates has is merely to advise the council as to whether it shall continue the publication of the Journal. This House of Delegates can merely express an opinion and the Council will be the body to decide the matter.

DR. CRAIG — The House of Delegates have to provide the funds, don't they?

PRESIDENT — The House of Delegates vote the sum of money to be appropriated for the next year.

SECRETARY — If the House of Delegates vote not to have the Journal, but if they vote to have it then the Council will take charge of it.

DR. HARDY — As I view it our members in Bangor haven't met with any great hardship in not receiving the Journal the past year, but I feel it would be very unwise to take a step backward in this Association and discontinue the publication of the Journal. Of course, in two years you cannot expect any number of editors to put an undertaking of this momentum and magnitude on any very efficient basis, and it seems to me that the House of Delegates should provide the funds for continuing the publication, and I make the motion that we continue the Journal another year and provide the funds for so doing.

DR. MARSH — I would like to say a few words in regard to the Journal. We must all understand that it is quite an undertaking for one or two men to run a Journal in the State of Maine and satisfy everybody in the County Societies and in this Association. Now there is one thing lacking I have no doubt and that is the successful cooperation of this entire Association. Our Editor, Dr. Gilbert, has not really had the support of all these County Societies, that is, the right kind of support. Now this is quite necessary in order to make this journal of ours a success, that we have papers from different Societies in order to get the reading matter. These papers that are received in this Association are mostly all published in the Journal, after we have heard them once, and we need something beside the papers we have heard, and if we wish to make a success of it, I believe it is necessary for every Secretary of the County Societies to send in at times different papers to be published in our Journal. Then we will get something that will interest our members in Piscataquis County, our members in Cumberland County, as well as in all the other counties, and this will very materially aid our Editor in giving us the best possible Journal.

DR. CAMPBELL — It seems to me we have hardly given this paper of ours a fair chance as yet, and I believe it would be a decided step backward to discontinue it. Of course there are some things about it that we would like to see changed, but I agree with Dr. Marsh that

it should have the co-operation of all the County Societies, and I shall vote to continue it for another year.

Upon motion it was voted to continue the Journal for another year and to provide the usual sum for its maintenance.

DR. HARDY — Our County Societies can help the editor of the Journal very materially if they are willing to do so, by having their Secretary send in from time to time the papers that are read before these individual societies. Each County Society might appoint a man to attend to that work and to see that all interesting items of news of the County Society reached the Journal. Up in Kennebec County, we have had several excellent papers — papers that have been enjoyed by all the members who were privileged to hear them and which would be enjoyed by any member of the profession, and these papers ought to have been published, to my mind. I think perhaps by having an official reporter for every County Society, we may accomplish more than we have done in the past.

DR. HILL — If my friend Hardy would make such a motion, I would like to second it.

It was unanimously voted that the Journal appoint a reporter from each County Society to prepare the transactions for each society in readiness for publication.

DR. GILBERT — I tried the first year we run the Journal to have each County Society appoint their own reporter and it didn't seem to work well. But now I think if each County Society will appoint a man to attend to this work it will be a great help to us in making the Journal interesting to the individuals.

DR. CRANE — I hardly care to hold out against the vote cast and I will withdraw my opposition. If we can have a man from each county who will give some time to the matter and look out for his county work, I think it will be worth while and I should favor it.

DR. SPEAR — What are the duties of the County Editors? Are they not supposed to send in all interesting items and papers read at their meetings?

DR. GILBERT — They are supposed to do that but they do not do it. I send out a postal the first of the month that the Journal goes to press; at a certain date, I send out another, and then on the 20th of the month, I send them another. I have done this over and over again but nothing comes from the county.

DR. HARDY — I think probably if a man in each county is chosen who will take some pride in attending to that work, who will be willing to give some time to it, and who will see that the Secretary or Editor of the Journal is kept in touch with all that is going on in his county,

that it will help very materially in making the Journal of interest to us all.

DR. CAMPBELL — It may be out of order, but we can see that Dr. Gilbert has worked very hard — I know that to be a fact, and I believe we should give Dr. Gilbert a vote of thanks for the efforts he has made in support of this paper.

PRESIDENT — Will you take that as a motion?

DR. CAMPBELL — I will, Mr. President.

The motion was unanimously carried.

On motion, it was voted to adjourn.

General Meeting of the Maine Medical Association.

Held in the Council Chamber, City Building, at eleven o'clock
July 12, 1912.

The meeting was called to order by President Stanley P. Warren, and the invocation pronounced by Rev. Jesse Hill of Portland.

PRESIDENT — Before taking up the first paper this morning, a matter has come up in the House of Delegates which I would like to have presented to this Assembly and discussed from the floor. I will ask Dr. Hill to present to you the matter of granting a section to the ear, eye, nose and throat practitioners. Shall the State Association accept the motion of Dr. Hill and unite in its suggestion that a section be formed on the ear, eye, throat and nose? The motion is now open before you and we will be glad to hear from anyone who wishes to make any remarks regarding the matter.

DR. HILL — In order that the members of the Maine Medical Association here present may fully understand the petition of ear, eye, nose and throat people, perhaps a little explanation from us might establish the matter a little more clearly. We have an organization of twenty-six men who are devoting their entire time to the ear, eye, nose and throat, and there are in the State perhaps twenty more who have not joined our organization because the object of our Association was to take up the matter of the eye and ear. We feel that there are members of our Association who get very little out of these meetings, as many in fact, most of the general subjects, are not of interest to the ear, eye, throat and nose men. I fail to see on this program anything that would specially interest the ear and eye men. I think I can say for myself that I attend these meetings fairly regularly — I rarely

miss them and enjoy listening personally, to the general subjects which are discussed each year, and we believe that it will not only strengthen the general organization if you give us a section, but it will strengthen our organization as well, and so we come to you with this request which I believe will be of benefit to us all and I sincerely hope you will grant our request at this time.

PRESIDENT — You have heard the motion of Dr. Hill. Has any one anything to say on the subject?

DR. JACKSON — I would like to ask if there is to be a section on medicine and surgery and if this could be held in the morning in connection with the meeting for the ear, eye, nose and throat?

DR. LITTLE — As Secretary of the Maine Ear and Eye Association, I will say that in order to be eligible one has to devote their entire time to the special subject, eye, ear, throat and nose. There are a great many members of the Maine Medical Association who spend part of their time in the treatment of these troubles and part of their time in general practise and these are not eligible to our Association, and we were thinking if we had our section here at these meetings then anybody who was interested in our work could attend the meetings and see and hear the work—anybody would be eligible. Then when we had our other meetings as we do through the year those would be individual meetings and might be more largely attended than they now are. We could reach the general members of this Association through this meeting if we are granted a section, and then we could come from our own meeting in to the general meetings and have the benefit to be obtained here. The entrance fees will be nothing, it will simply be to be registered in these meetings and through the Journal. Notices will be sent out as to the program, and I cannot see any objection to it whatever. It will not interfere with the Maine Medical Association as our meetings could be arranged earlier in the morning that the general meetings would be held.

PRESIDENT — Are the members of the Maine Eye and Ear Association all members of the State Association?

DR. LITTLE — They are.

PRESIDENT — I think that is all the question I wish to ask. Anything else to be said on this subject?

DR. HARDY — I fail to see why this Association should recognize any particular class of practitioners. This is an association of the medical men of Maine, and I think the general object is to provide an interesting program for everybody who attends. By dividing the program into sections and giving a section to medicine and surgery, a section to the specialties and a section to the ear, eye, throat and nose men, you will give every member an opportunity to choose the papers

that are most interesting to him. I think we should be careful and not choose any particular line of specialties and give them a section and deny a like privilege to other lines.

DR. GORDON — I would like to say a word in relation to this matter of dividing our Association up into sections. I have no doubt the time is coming when it may be found best to have it divided up into sections but it seems to me now that with the number of members we have, we would not get more than two hundred and fifty members in at any one meeting and it appears to me that we can't afford to establish this matter of sections just at present. If we start in and make one section, it seems to me we shall have to make more. The American Medical Association, of course, is much larger and is divided up into sections and everybody who attends may attend the section he chooses and in which he is most vitally interested, and each room is ordinarily filled at their meetings. But I am rather inclined to believe we had not yet better begin sectionalizing — not just at present. When we grant this section to the ear and eye folk, we are establishing a precedent that will divide our society, which is comparatively small, a little too much. This is a big State, I know, and contains lots of doctors, but it still seems to me we had better not begin dividing our Association up into sections just at present.

DR. HILL — With all due respect to my good friend, Dr. Gordon, whom I esteem highly — I don't believe he understands the situation as we do — I do hope you will give us a section for the ear, eye, throat and nose men. We have an organization as I have stated which has existed for ten years, and we are unanimous — or practically so — I have not interviewed each one, but we have been patiently waiting for the time to come when we might have a section by ourselves — I do not mean alone by ourselves, but a section where anyone interested in our work could assemble and see what we are doing. The idea is, you can help us by granting us a section at these yearly meetings and we do want you to do so. We believe that if you will grant us this privilege that we can materially increase our membership and our interest and improve ourselves, and it seems to me we ought to be granted this trial trip. If you do not like it we will gladly consent to its abolishment, but I do feel that you will be doing yourselves good by granting this request today.

DR. GORDON — Do you wish to occupy a room by yourselves?

DR. HILL — We would hold our meeting in the morning the same as the Council and the House of Delegates do, the first day. Perhaps have one good paper open to everybody — perhaps hold our meeting in this place while the Council and House of Delegates were in their room. In that way we would not be taking valuable time from the

general meetings, and it would be a good way to try out the experiment. I think we would bring twenty-five or thirty extra members of the Maine Medical Association to this meeting, while on the other hand if we do not have this section, these same members will not make the effort to come here because they say they do not get value received for their time and money. But if they came to hear the discussion on the ear and eye, they would stay right through the general meetings.

PRESIDENT — Anything further to be said on this subject? If not, the motion is before you for action. You all understand, I think, what the motion is — that the Association adopt a section on the eye, ear, throat and nose. Those in favor say "Aye," and stand while you are counted by the Secretary. Eighteen members voted in favor of the motion, while eleven members voted in the negative.

Upon the report of the Secretary, the motion was declared carried.

DR. HILL — In behalf of our Association of ear, eye, nose and throat men, I want to thank you for your courtesy and kindness in this matter.

PRESIDENT — Are there any representatives of State Societies or other bodies present this morning? If there are will they please come forward?

The first paper to be presented this morning is on "Certain Aspects of Arterio-Sclerosis," by T. J. Burrage, of Portland.

Dr. Burrage reads paper.

PRESIDENT — The next paper on our program is "Malformation in Development of Superior Maxillary Bone," by Dr. S. J. Beach of Augusta.

Dr. Beach reads paper.

PRESIDENT — We have a volunteer paper by Dr. Sturgis of Auburn, which I think will prove of interest to us, and which the doctor will now read.

Dr. Sturgis reads paper.

PRESIDENT — I want to announce that the courtesy of several of our clubs has been offered us, the Portland Club, the Portland Athletic Club and the Country Club, where we play golf.

The meeting adjourned at this point until two o'clock P. M., to meet at that hour in the same place.

W. BEAN MOULTON,
Secretary.

General Meeting.

AFTERNOON SESSION.

FIRST DAY.

The meeting was called to order at two o'clock by Dr. Peters of Bangor, Vice President, who in a very happy manner introduced President Warren, as the first speaker on the program.

Dr. Warren presented the annual address of the retiring President and was listened to with much attention.

DR. GORDON — Mr. Vice President, I move the vote of the Association be tendered to our President, Dr. Warren, for this interesting literary production.

The Association so unanimously voted.

I beg to submit the following report of my visit to the New Hampshire Medical Meeting:

On my arrival at the meeting-place, I was received with a cordial handshake by one of the members of the Committee, who escorted me to the registrar and later saw that I was taken into the hall where the meeting was held and introduced me as the delegate from Maine.

I attended three sessions where five papers were presented at each session. There seemed to be ample time for reading and discussing with the periods given, while the papers and their subjects were well worthy of consideration.

All routine business was done outside of the regular meeting in the House of Delegates.

The local medical organization gave a splendid entertainment the first evening at the Snowshoe Club, while the second evening was devoted to the annual banquet which was held at the Eagle Hotel, Concord, N. H., to which the ladies were invited. During the banquet, music was furnished by an orchestra, also a quartet sang some few selections and immediately following the banquet, there was a series of after-dinner speakers headed by Gov. Robert P. Bass of New Hampshire, who spoke words of welcome in a witty and very pleasing way. In addition to the regular speakers, the delegates from the different States were called upon to respond in behalf of their own State and on the whole, it was one of the most pleasant banquets that I have ever had the pleasure of attending. I can strongly recommend the activities of the profession of New Hampshire and their hospitality to delegates visiting their State meeting.

F. Y. GILBERT,

Delegate.

PRESIDENT WARREN — The first paper on the program for the afternoon, is "The Etiology and the Early Diagnosis of Paresis," by Frederick L. Hills, of Bangor.

Dr. Hills reads paper.

DR. GORDON — I omitted, Mr. President, when speaking of your most excellent address today, to do what is ordinarily the custom for us to do upon occasions of that kind, namely, to move that a committee be appointed on the President's address, and I now take

pleasure in moving you gentlemen that a committee of three be appointed to act on the President's address.

DR. WARREN — I will appoint Dr. Mason of Calais, Dr. Bennet of Lubec and Dr. Williams of Bangor.

PRESIDENT WARREN — The next paper to be presented is by Dr. Henry W. Miller of Augusta, and his subject is "General Paralysis—Pathology."

Dr. Miller presents paper.

PRESIDENT — The next paper we shall have in this symposium is on "Symptomatology," by Dr. Hedin. Dr. Hedin, gentlemen.

Dr. Hedin, First Assistant Physician at the Maine Insane Hospital, Augusta, Maine, then read the following paper, "Symptomatology and Clinical Types in General Paralysis."

PRESIDENT — The next and final paper in the symposium is by Dr. Herbert E. Thompson of Bangor, "Laboratory Aids in Diagnosis of General Paralysis."

Dr. Thompson reads paper.

Following the discussion of the foregoing papers, a recess of five minutes was taken.

PRESIDENT — Gentlemen of the Association, It has been several years since we have had any extended paper on obstetrics. Last July, I took pains to arrange for the oration which will be delivered to you in a few minutes. I am sure I have secured for you the best man it would be possible to get. The gentleman who is to deliver the oration is a man of large experience and the head of the largest hospitals in the United States and possibly in the whole world. He is also a Professor of Obstetrics and Gynecology in the Medical Department of the Columbian University, as well as being in charge of the Sloan Hospital for women in New York, and I have found at least a dozen other titles which belong to him which I have left out because of his modesty. It gives me great pleasure, gentlemen, to introduce to you Dr. Edwin B. Cragin of New York, who will now address you on "The Present Status of Modern Obstetrics."

Dr. Cragin then presented his oration.

DR. GORDON — Having been associated with Dr. Cragin for a great many years, I was much pleased when I learned he was coming to our meeting to address us. At the meetings of the Gynecological Society, we always consider it a great treat when Dr. Cragin has had a paper, and if he did not have a paper, we have always considered it a treat to listen in the discussions of his favorite topic. He is one of the bright men in the Society, and a man whom we miss when he is absent from the meetings as he was week before last. He has

come to us here in Maine at considerable sacrifice, I happen to know, and I also know that it is a great pleasure for him to come to Maine. It certainly has been a great pleasure to us to have him with us and to have the pleasure and privilege of listening to his very instructive paper, and I know I only speak the sentiments of the Maine Medical Association when I move that a vote of thanks be extended to Dr. Cragin for his very valuable address which he has delivered to us today.

A unanimous rising vote was given.

The meeting adjourned until the following day at eleven o'clock in the forenoon, to meet in the Council Chamber.

Announcement was made of the banquet to be held at the Falmouth Hotel at 7.30 P. M.

House of Delegates.

THURSDAY MORNING.

SECOND DAY.

June 13th, 1912.

Aldermen's Chamber. City Building. Portland, Maine, at nine o'clock, meeting was called to order by President Warren, who called upon Dr. F. N. Whittier of Brunswick for the Report of the "Committee on Venereal Diseases and their Prevention."

DR. WHITTIER — I will say, Mr. President, that my report is a tentative one. While I think the other members of the Committee will have no hesitancy in signing it, I want to make it with that understanding. This is the report as written for the Association, but the Committee have not read the report, but for all that I presume they will have no hesitancy in signing it. The report follows:

Mr. President, and Members of this House of Delegates:

In the report of your Committee presented June 29th, 1911, the following recommendations were made:

1. That this Association recommend to the State Board of Health the sending out of circulars of information on Sex Hygiene to school superintendents, with the request that such circulars be distributed among teachers, also among pupils when it is deemed advisable.
2. That this Association recommend to the State Board of Health that syphilis, gonorrhea and chancroid be added to the list of diseases which physicians are required by law to report to the State Board of Health, with the provision that the diseases mentioned may be reported by number instead of

by name, and shall be accompanied by the physician's statement relative to facts concerning source of infection.

3. That a Committee of this Association be appointed for co-operating with the State Board of Health in carrying on a campaign of education of the public as regards the importance of the prevention of venereal disease.

These recommendations were accepted by the Association and your Committee was empowered to carry them out as far as possible. The members of the State Board of Health early expressed themselves as being in sympathy with the work of your committee, but it was pointed out that the State Board of Health had no funds at its disposal, and so could not co-operate actively in the work of your committee.

It seemed to the committee that one of the best ways of carrying on a campaign of education of the public as regards the prevention of venereal disease, was according to the plan advocated by Dr. Bailey of Harvard of sending carefully worded circulars of information on sex hygiene to parents, with the request that the parents read the circulars, and if they found nothing questionable or objectionable in them, to give them to their children to read when they reached a suitable age. Parents are further requested in case they find anything objectionable in the circulars, to notify the committee of their objections.

In order to carry out this work, it was necessary to have funds and accordingly a statement of conditions was sent out to about two hundred people who seemed likely to be interested, showing the need of funds, although not directly soliciting contributions. It was hoped to raise \$500 in this way. Already, as a result of these letters, a fund of \$485 has been contributed. This has been deposited in the name of the committee in the Brunswick Savings Institution, and is now available for carrying on the work of the committee.

Following are the names of the subscribers to this fund:

Mrs. Mary S. Cobb, Cambridge, Mass.,	\$ 25.00
Dr. G. A. Phillips, Bar Harbor,	25.00
Dr. F. H. Jackson, Houlton, Me.,	5.00
Dr. E. E. Holt, Portland,	25.00
Dr. F. N. Whittier, Brunswick,	25.00
Misses Mary and Mabel Davies, Portland,	25.00
Prof. and Mrs. Geo T. Files, Brunswick,	25.00
Bishop Robert Codman, Portland, has raised, contributed by Mr. Herbert Payson, Mr. C. H. Payson, Mr. F. E. Richards, Mr. C. F. Libby, Mr. Elias Thomas,	110.00
Ex-Governor Selden Connor, Augusta,	5.00
Ex-Governor Bert M. Fernald, West Poland,	5.00
President A. J. Roberts, Colby College,	10.00
Dr. Sylvester Judd Beach, Augusta, has raised, contributed by S. C. Manley, T. B. Stevenson, N. L. Bassett,	30.00
Dr. D. A. Sargent, Harvard University,	10.00
L. A. Burleigh, Augusta,	5.00
Mr. Robert E. Gardiner, Gardiner,	50.00
President William DeWitt Hyde, Bowdoin College,	10.00
Mr. Berton C. Morrill, Bowdoin College,	10.00
Mrs. Margaret Deland, Boston, Mass.,	5.00

Dean K. C. M. Sills, Bowdoin College,	5.00
E. T. Burrowes, Portland,	25.00
Dr. S. C. Gordon, Portland,	5.00
Mr. Hiram T. Ricker, Poland Springs,	10.00
Mrs. Gertrude E. Macy, Pasadena, Cal.,	5.00
"A Friend,"	10.00
Interest accrued,	15.00
	<hr/>
	\$485.00

The committee was much pleased by the responses to the letters sent out. Among the endorsements received were the following:

Dr. B. L. Arms, Director of Bacteriological Laboratory of Boston Health Department.
 Dr. Marshall E. Bailey, Medical Advisor, Harvard University.
 Dr. Sylvester Judd Beach, Augusta.
 Rev. Raymond Calkins, Portland.
 Mrs. Mary S. Cobb, Cambridge, Mass.
 Rev. Robert Codman, Bishop of Maine, Portland.
 Ex-Governor Selden Connor, Augusta.
 President, George C. Chase, Bates College.
 Misses Mary and Mabel Davies, Portland.
 Ex-Governor Bert M. Fernald, West Poland.
 Dr. Frederick H. Gerrish, Portland.
 President William DeWitt Hyde, Bowdoin College.
 Hon. John D. Long, Boston, Mass.
 Dr. Prince A. Morrow, President of the American Society of Sanitary and Moral Prophylaxis, New York.
 Dr. W. Bean Moulton, Secretary of Maine Medical Association.
 Mr. George W. Norton, Editor of *Portland Evening Express-Advertiser*.
 Dr. George A. Phillips, Bar Harbor.
 Mr. Hiram W. Ricker, South Poland.
 President A. J. Roberts, Colby College.
 Dr. Dudley A. Sargent, Director of Hemenway Gymnasium, Harvard University.
 Dr. Charles D. Smith, Member of the State Board of Health.
 Hon. Payson Smith, State Superintendent of Schools.
 Dr. S. P. Warren, President of Maine Medical Association.
 Mrs. M. T. W. Merrill, Fryeburg.
 Dr. A. G. Young, Secretary of State Board of Health.
 Dr. L. M. Palmer, South Framingham, Mass.

Letters have been sent out to all the Secretaries of the State Boards of Health in the country, asking their opinion of placing venereal diseases among those required to be reported to the State Board of Health, provided that they be reported by number rather than by name, as is now done in the States of California and Utah; also asking for suggestions as to the best means of fighting venereal disease. A majority of all the replies received were in favor of making venereal diseases reportable by number to the State Board of Health.

Through the kindness of State Superintendent of Schools, Payson Smith, your committee has been favored with a list of local school superintendents

interested in the work and letters have been sent to eighteen of these representatives of the different sections of the State. Already a sufficient number of names of parents of children of suitable age have been received to enable the committee to begin its work of sending out circulars of information in sex hygiene.

A special joint meeting of the State Board of Health and your Committee was called on June 8th, 1912, to consider the question of prevention of venereal disease in this State.

As a result of this meeting, the State Board of Health passed the following resolutions:

Resolved, That this Board approves a plan of disseminating information among superintendents of schools and parents upon sex hygiene and the danger of venereal infection.

Resolved, That the State Board of Health is ready to co-operate with the members of the medical profession, as represented by the Committee on Venereal Diseases and their Prevention, of the Maine Medical Association, in the protection of the community and the education of children along the lines indicated by the foregoing resolution.

Resolved, That it is the sentiment of this Board that syphilis, gonorrhea and chancroid should properly be included in the list of infective diseases, made reportable by law, provided such venereal diseases be reported by number and not by name.

Your Committee makes the following recommendations:

1. That your Committee be empowered to work with the State Board of Health in disseminating information among Superintendents of Schools and parents upon sex hygiene and the danger of venereal infection.
2. That your Committee be empowered to develop public opinion for including syphilis, gonorrhea and chancroid in the list of infective diseases, made reportable by law, provided such venereal diseases be reported by number and not by name.

There is one other matter I would like to present and that is the matter of having a recommendation from the House of Delegates for a small appropriation from the Maine Medical Association. To be sure, we have the sum of \$485.00 on deposit in the Savings Bank, and of course we have the necessary money to go to work with; but the Committee feels that it would be much better if we could feel at all times that the Association was back of the Committee and that they would back up our work by voting us a small sum. If the Association would give us, say fifty dollars, we should then feel that it was back of us and it would help very materially in the work, we feel. If you will give us this nominal sum, it will help us to raise more. It will enable us to say to the people who ask us who is behind this movement that we have the backing of the Maine Medical Association. That would be a great help to us, I am sure. I would like to ask the recommendation of the sum of fifty dollars—that that sum be appropriated to the work of this Committee on Venereal Diseases and their prevention.

PRESIDENT—You hear the report of Dr. Whittier, Gentlemen. Unless there are objections to it, it will be accepted. Shall we pass a resolution to appropriate \$50 to the use of this Committee?

SECRETARY—I will say in regard to this appropriation that the

Council is supposed to be the Finance Committee, and they are the ones to act upon matters of this kind instead of the House of Delegates.

PRESIDENT — There are two things I want somebody to do. I want somebody to write a resolution favoring good roads, and I want another resolution in the matter of the State Board of Charity about which Mr. Whitehouse talked to us last night.

DR. PETERS — Would it not be possible to get the people who spoke on those subjects last night to draw up a set of resolutions and have them endorsed by the House of Delegates?

PRESIDENT — I don't know but that we could get Mr. Whitehouse to draw up resolutions.

DR. JACKSON — Why can not Dr. Peters write out a set of resolutions on State Charities?

DR. PETERS — We will get Mr. Whitehouse to do it.

PRESIDENT — How about the resolutions on good roads?

SECRETARY — I don't think we ought to lose the valuable services of Dr. Peters.

PRESIDENT — Dr. Jackson, are you ready to read your report as a member of the Cancer Committee?

DR. JACKSON — I have no written report with me, Mr. President. I neglected to bring one. I was unable to get hold of Dr. Swasey and Dr. Webber. We planned to meet here, but afterwards I saw him and he said he regretted that he could not come. I will make this verbal report for the Committee:

At the last meeting of the Maine Medical Association, the Committee on Cancer was re-appointed, and made certain recommendations before the general session that the work of the Cancer Committee be helped along by as much publicity as possible; that it endeavors to have each County Society hold at least one meeting during the year at which the subject of cancer should be thoroughly presented to its members, and also that each County Society should hold at least one meeting to which the public should be invited, at which the subject of cancer should be presented in a logical manner before the whole audience. Also that it should attend to the publication of certain articles on the subject of cancer, as has been done with tuberculosis. The Committee finally decided to omit the articles in the press and try that another year. We feel that the work of the Committee has accomplished something; of course, we have not accomplished all we would have been glad to do, but we have done something. A few years ago, we could make practically no headway along these lines, so that we feel very much encouraged at what we have been able to do, and at the responses that have met our recommendations. We feel there will be a little more enthusiasm each coming year and that it will be easier to pile up results. We have gotten some very favorable responses from all over the State, and I might say that the men all seem to be interested in the matter and to believe in the work and seem to want it continued and enlarged, as does your Committee.

I will say that Washington County held one meeting in accord with these recommendations and all the suggestions made by the Committee were well carried out. They had a general session of the Washington County Medical Society, at which the Chairman of the Committee read a very interesting paper on the subject, and they also had a public meeting at which Dr. Webber and a great many of the business men from that part of the State were present, and they have all been loud in their praise of the thorough and simple manner in which the subject of cancer has been brought before the public, and the Society has been assured that they will have a great deal larger audience than before, when they have another public meeting to discuss this subject.

A great many County Societies have had special meetings devoted to cancer, and in each instance there has been a good deal of interest and we feel that the work will be continued. There seems to be a great deal being done by the general profession, and I would ask that the Association recommend that we be given fifty dollars with which to carry on the work. We had appropriation of \$50 last year and out of that we only used \$13.44, and we shall be just as careful this year, but we would like to feel that we had your backing to this extent. I did all the typewriting last year myself and was glad to, and we will all work as hard as it is possible this year, but we earnestly hope you will see your way clear to help us to carry on the work. It took you a great many years work up popular enthusiasm in regard to tuberculosis, and it will probably take the same amount of time to work up the feeling in regard to cancer and the conditions surrounding it, but your committee earnestly requests that you make the appropriation of fifty dollars for another year. The County Societies have promised to do all they can to help us in the work and we feel that they will do so, and we believe that the work will go along much easier this year than it has done in any previous year.

PRESIDENT — The report of the Cancer Committee will be accepted and printed unless otherwise objected to, and I think there is no doubt but that we will get Dr. Jackson's fifty dollars for that Committee for him.

PRESIDENT — Pending the time of nominating the officers for the ensuing year, I think the committees that are appointed might be made up. That will save us some time later on. Will you nominate three persons to be appointed on these committees, or shall the chairman appoint from the chair? The chairman is ready to receive suggestions.

SECRETARY — It seems to me it would be as well to allow some of these committees to stand as at present, for instance the Cancer Committee as formerly appointed, they have been doing this work and know the business and have done it successfully thus far, and it seems to me they are in a better position to carry the work along than a new committee would be. The same is true of the Committee on Venereal Diseases and Their Prevention. They have done a lot of routine work, and the best results would probably be obtained by allowing them to continue for another year and work the thing out as they have begun it.

I would also make the same suggestion in regard to Dr. Spalding in the matter of continuing him as the Committee on Necrology. He

takes a great deal of pride and pleasure in doing this work. I don't know how he finds out so much about how all these people die; he must read the reports and newspapers in every State in the Union. Anyway he finds out everything in that line that takes place and gets all the news possible in relation to it. He is remarkable in that line and I would suggest that he be re-appointed as Necrologist.

DR. MARSH — I move the Committee on Cancer, the Committee on Venereal Diseases and Their Prevention and the Committee on Necrology be continued for another year just as they are. We cannot afford to take them off.

The motion was unanimously carried.

PRESIDENT — The Chair will appoint Dr. Marsh, Dr. Spear and Dr. Sylvester as the Nominating Committee to nominate the officers for the ensuing year, and they will report at their convenience.

We will now listen to the report of Dr. Bennett, our Delegate to the American Medical Association. Dr. Bennet, of Lubec, Gentlemen.

Dr. Bennet read the following report:

Mr. President and Members of the House of Delegates:

I feel that I am under obligation to you for the honor conferred upon me when you elected me Delegate from the Maine Medical Association to the House of Delegates of the American Medical Association, the greatest Medical Association in the world today.

Had I fully understood the magnitude and make-up of the National House of Delegates, I should surely have advised that a more competent man, one more widely known among the members of the profession, and one who has had more extensive training along parliamentary lines be sent, for as I see it now, the position is one of great importance to this society.

You have all heard that the American Medical Association was simply a political machine, but so far as I could understand the situation, such a stigma is not justifiable. In a body of this kind, much of a political nature must enter, but if this is of an honest character, no fault should be found, in fact it is indispensable.

Again, here as in similar organizations, a few do most of the work, but this only shows that "those who will, may." If some men are more progressive, more enthusiastic, more thoroughly in earnest than others, then those who lag behind should not complain.

My personal opinion is, that the members of this society should take more interest in the National Association. We should not be content in sending Delegates as a matter of routine, but surely should have at least *one* in each section.

There can be no doubt about the high order of the work done in the different sections, and this should be sufficient inducement to attract the interest of members of this society, and induce them to attend.

For example, the clinic given by J. B. Murphy in the surgical section would well repay any surgeon for the trip to Atlantic City, to say nothing of all the other good things in that section. The same would be true of other sections. I cannot say much of section work because my time was mostly devoted to the House of Delegates.

The entire delegation from any State should co-operate and act in a body for the best interest of the profession in their State. In this way any tendency to machine rule would be checked, and the best interests of the entire profession secured. It is unwise to complain of misrule in any organization unless you have made an earnest effort to correct it.

The House of Delegates this year was made up of about 150 members, coming from the extreme limits of this great country. I believe the intention is not to materially increase this number. The new apportionment gives to each society one delegate for every 700 members, or a fraction thereof. This should be a stimulus for each of our county societies to double their efforts in securing eligible members, and thus gain the right of sending two delegates to the National House.

Last year no alternate was elected. This should not occur again, as it might be impossible for the delegate elected to attend. In this case the society would not be represented.

There seems to be a strong feeling in the National Society in favor of more thorough organization work. This seems to me to be just what we need in Maine.

The last edition of the Medical Register gives Maine 1,198 physicians, and but 606 or 50.5% of these are members of the State Society. These facts were compiled May 1, 1912. This indicates a need for more campaign work of a systematic character.

Would it not be well for the County Societies to devote a part of one meeting each year to work of this kind?

The next meeting of the "A. M. A." will be held in Minneapolis, Minnesota, June, 1913.

An important part of the work of the Association is the arrangement for important clinics both at the place of meeting and in nearby cities. The clinics held in nearby cities before and after the annual meeting, as well as those held during the session, are very important and practical, and have something valuable for each and every one, no matter what his field of labor may be.

Next year, the chief places of attraction in this connection will doubtless be Chicago and Rochester where skim milk will not be served for cream. I sincerely trust a goodly number from this Society will show up at Minneapolis, next year. I would not hesitate to guarantee satisfaction.

Dr. Bennet's report was accepted and ordered spread on the record.

PRESIDENT — I wish we could all go to these meetings, but we are most of us poor and have to spend our money for charity and a new home for the Boys' Club and numerous other things.

We have a report of W. D. Williamson, who was the representative to the Vermont Medical Society. Dr. Williamson, Gentlemen.

Dr. Williamson read the following report:

Members of the Maine Medical Association:

It was my privilege and pleasure, as a delegate to the Vermont State Medical Society, to be present at the annual meeting, October 12th and 13th, 1911, at Burlington, Vermont. It was my privilege because you made it so. It was my pleasure for several reasons, one because it gave me an opportunity to visit the University of Vermont, where I was taught the first lessons that

pertain to our profession, and where I obtained the degree of M. D., by having completed the then prescribed course of study.

The meeting was well attended and the members took part in the discussion of the papers quite freely with interest and enthusiasm. The papers were all of considerable merit, but a few of them I believe worthy of special mention.

The first was a paper on "Radiculitis," by A. H. Bellerose of Rutland, Vermont. It being an inflammatory process of the radicle of the spinal nerves. The paper on "Diagnosis of Renal Tuberculosis," by W. W. Townsend of Rutland, Vermont, deserves special mention, dealing with the common subjective and objective symptoms and also the bacteriological diagnosis.

The address of G. W. Crile of Cleveland on "Anoci-association," was interesting and quite typical of the man, showing original research. Dr. M. B. Hodskins of Palmer, Mass., gave a clear and concise resume of acute poliomyelitis, taking up the nature of infection and frequency of occurrence, method of transmutation. Is there a similar disease in animals?

The meeting was concluded with a banquet in the evening, to which the ladies were especially invited. This appealed to me and I feel that we might, once in a while at least, adopt this or something similar, that our wives could participate in, as I am sure much of our success as physicians is largely due to the help we get from those most deeply interested in our work and success, viz.: our wives.

Dr. Campbell of Augusta, then read the following resolution on the subject of "Good Roads."

The subject of good roads for the State of Maine is one of the most important before the people of the whole State. It is the opinion of the House of Delegates that some action should be taken by this Association.

Be it therefore Resolved, that the Maine Medical Association put themselves on record as heartily in favor of the movement to improve our State highways, and that a Committee be appointed who shall use every honorable means to promote this result.

The resolution was unanimously accepted.

DR. SYLVESTER — I would like to ask a question in regard to the matter of nominations. We seem to lack a few instructions. Here are two vacancies in the Councillors. Are they nominated by the Nominating Committee?

SECRETARY — They are elected from the floor.

DR. SYLVESTER — What are the officers to be nominated by this Nominating Committee? Will you please give us a list?

PRESIDENT — Everything but the President.

SECRETARY — I find last year the Councillors were elected from the floor. Two years before that that custom was not followed. Last year they were elected by nomination from the floor.

PRESIDENT — Here is your list of officers, Dr. Sylvester. Two Vice Presidents, two Councillors, one for the First and one for the Second District, Cumberland and York Counties, and Androscoggin, Franklin and Oxford Counties, a Secretary, Treasurer, and although we have never done so before, it has been suggested that an Alternate

Delegate to the American Medical Association who is elected for two years, two visitors to the Medical School, two visitors to the Maine Insane Hospitals, a Committee on Scientific Work, Committee on Policy and Legislation, Committee on Necrology — that has already been taken care of by re-electing Dr. Spalding, also the Committee on Venereal Diseases and Their Prevention and the Committee on Cancer have been taken care of.

And I offer this merely as a suggestion, would it not be a good idea to appoint delegates to the different State Societies? It is a perfect nuisance to the President to worry his brain to find out whom he had better appoint as a delegate to these different meetings. If the men who would like to go and who would be able to go would only indicate their wish, it would help the President remarkably. As it is, he picks out someone and perhaps that one has no interest in going or may be unable to go and so the meeting is lost.

SECRETARY — I think that was brought up yesterday, if I remember, and it was voted that a request be published in the Journal that any members desiring these appointments should apply to the President and he might use his discretion in making the appointments.

PRESIDENT — Doctors as a rule are very modest men and very few of them will ask for appointments of this kind it has seemed to me, but certainly that is a good way to arrange the matter.

SECRETARY — That is what was voted. The idea is if a man has any special reason for wishing to go into any special locality to attend one of these meetings, let him indicate it to the President and the President will do as he sees fit about appointing him a delegate.

PRESIDENT — It has been a very disagreeable task to pick out men for these places as the President has no way of knowing what meetings one man would like to attend and what meetings would not appeal to him. At two or three of the State Societies, we did not have any men there; we did send a delegate to Vermont and New Hampshire, but I don't think anybody went to Massachusetts, Rhode Island or Connecticut.

PRESIDENT — I think the report of the Treasurer is the next matter to come before us. Dr. Gehring will now give us the report:

TREASURER'S REPORT OF MAINE MEDICAL ASSOCIATION.

RECEIPTS.

1911

June 1	To cash in treasury,	\$2,987.39
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1912

June 2	To interest, Mercantile Trust Co.,	32.39
	“ Portland Savings Bank,	28.36
	“ Fidelity Trust Co.,	25.47
	Cash from annual dues,	1,459.00

\$4,532.61

DISBURSEMENTS.

1911			
June 9	By cash paid St. Louis Button Co.,	bill,	\$ 8.00
16	" Stephen Berry Co.,	"	83.25
July 5	" W. Bean Moulton, salary, 1910-1911,		200.00
5	" W. Bean Moulton,	bill,	25.50
	" R. W. Wakefield,	"	15.00
	" G. R. Campbell,	"	5.95
	" E. W. Gehring, salary, 1910-1911,		25.00
7	" Union Safe Deposit & Trust Co., Treas.'s bond,		10.00
22	" R. H. Stubbs, M. D.,	bill,	6.00
	" Fred S. Rand,	"	5.00
	" Maine Medical Journal,		600.00
29	" L. B. Raynes,	"	67.50
Aug. 5	" S. P. Warren,	"	18.00
16	" S. P. Warren,	"	17.05
16	" H. W. Ingalls,	"	.75
17	" Hiram Hunt, M. D.,	"	16.30
22	" The Aroostook Pioneer,	"	2.50
Sept. 27	" S. P. Warren,	"	7.00
Oct. 13	" S. P. Warren,	"	3.35
23	" S. P. Warren,	"	12.40
24	" E. F. Moore,	"	1.96
Dec. 27	" S. P. Warren,	"	4.10
27	" American Medical Association,	"	1.25
11	" S. P. Warren,	"	6.70
1912			
Jan. 27	" R. H. Marsh,	"	5.80
Mar. 4	" Maine Medical Journal,		500.00
27	" Dow & Pinkham,	"	14.40
Apr. 20	" S. P. Warren,	"	10.85
25	" Wm. W. Roberts Co.,	"	2.00
May 3	" E. W. Gehring, Salary 1911-1912,		25.00
June 1	" E. H. Bennett,	"	60.00
2	" Balance in Treasury,		2,772.00
			<hr/>
			\$4,532.61

REPORT OF THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION.

RECEIPTS.

July 1	To cash in treasury,	\$ 11.86
22	To cash received Maine Insane Hospital,	2.00
22	" W. B. Thombs,	9.00
22	" Maine Medical Association,	600.00
29	" Maine Advertising Co.,	20.00
Sept. 12	" Edmund H. Stevens (Sub.),	2.00
Oct. 21	" Advertising,	50.00
Dec. 7	" D. Hennessey,	2.00
7	" Maine Advertising Co.,	42.84
16	" Maine Acad. Med. & Science,	265.90
19	" Advertising,	50.00

1912			
Jan. 10	To cash received	Maine Advertising Co.,	\$72.71
13	"	Advertising,	12.50
Mar. 4	"	Maine Medical Association,	500.00
16	"	Advertising,	56.25
23	"	Maine Advertising Co.,	59.69
29	"	Bowdoin College,	2.00
Apr. 9	"	Advertising,	35.21
1911			
			<hr/>
			\$1,793.96

DISBURSEMENTS.

July 29	By cash paid	Eileen F. Moore,	bills	\$13.50
Aug. 5	"	Eileen F. Moore,	"	6.00
5	"	Wm. W. Roberts Co.,	"	1.75
8	"	E. F. Moore,	stamps,	20.00
12	"	F. Y. Gilbert,	bill,	15.00
12	"	H. R. Harrower,	"	2.00
12	"	Eileen F. Moore,	"	6.00
16	"	Stephen Berry Co.,	"	79.05
19	"	E. F. Moore,	"	6.00
Sept. 9	"	E. F. Moore,	"	18.00
9	"	E. F. Moore,	stamps, etc.,	20.00
9	"	Wm. W. Roberts Co.,	bill,	7.40
9	"	Stephen Berry Co.,	"	89.25
16	"	E. F. Moore,	"	6.00
27	"	E. F. Moore,	wrappers,	10.00
27	"	E. F. Moore,	wrappers,	6.00
27	"	F. Y. Gilbert,	bill,	5.00
30	"	E. F. Moore,	"	6.00
Oct. 11	"	E. F. Moore,	"	6.00
11	"	E. F. Moore,	stamps,	5.00
11	"	Frank I. Moore,	bill,	40.00
13	"	E. F. Moore,	"	6.00
13	"	Stephen Berry Co.,	"	91.28
21	"	E. F. Moore,	"	6.00
21	"	Wm. W. Roberts Co.,	"	4.28
28	"	E. F. Moore,	"	6.00
28	"	E. F. Moore,	stamps, etc.,	15.00
Nov. 4	"	E. F. Moore,	bill,	6.00
11	"	E. F. Moore,	"	6.00
16	"	E. F. Moore,	"	1.00
18	"	E. F. Moore,	"	6.00
18	"	Stephen Berry Co.,	"	80.70
25	"	E. F. Moore,	stamps, etc.,	20.00
25	"	E. F. Moore,	bill,	6.00
Dec. 2	"	E. F. Moore,	"	6.00
9	"	E. F. Moore,	"	6.00
9	"	Wm. W. Roberts Co.,	"	1.70

Dec. 15	By cash paid	E. F. Moore,	bill,	\$ 6.00
15	"	F. Y. Gilbert,	"	13.09
16	"	Stephen Berry Co.,	"	89.85
20	"	E. F. Moore,	"	12.00
1912				
Jan. 3	"	E. F. Moore,	wrappers,	17.17
6	"	Stephen Berry Co.,	bill,	81.59
6	"	E. F. Moore,	"	6.00
13	"	F. Y. Gilbert,	"	1.00
13	"	E. F. Moore,	"	6.00
22	"	E. F. Moore,	wrappers,	17.17
22	"	E. F. Moore,	bill,	6.00
Feb. 3	"	E. F. Moore,	"	13.00
3	"	E. F. Moore,	stamps,	8.00
10	"	E. F. Moore,	bill,	6.00
10	"	Stephen Berry Co.,	"	5.13
10	"	Wm. W. Roberts Co.,	"	2.30
24	"	E. F. Moore,	bills,	12.15
24	"	E. F. Moore,	wrappers,	18.00
Mar. 1	"	E. F. Moore,	bill,	6.00
4	"	Marks Printing House,	"	114.40
16	"	E. F. Moore,	"	12.00
23	"	E. F. Moore,	"	6.00
29	"	E. F. Moore,	"	6.00
29	"	E. F. Moore,	wrappers,	18.00
Apr. 1	"	Southworth Printing Co.,	bills,	16.25
1	"	Marks Printing House,	bill,	90.40
4	"	Wm. W. Roberts,	"	3.00
5	"	E. F. Moore,	"	6.00
12	"	E. F. Moore,	"	6.00
20	"	E. F. Moore,	"	6.00
20	"	Marks Printing House,	"	84.00
29	"	E. F. Moore,	"	24.50
May 4	"	E. F. Moore,	"	6.00
6	"	Wm. W. Roberts,	"	1.00
11	"	E. F. Moore,	"	6.25
16	"	E. F. Moore,	"	6.00
28	"	E. F. Moore,	"	24.00
28	"	Southworth Printing Co.,	bills,	7.25
June 1	"	Balance in treasury,		388.55

 \$1,793.96

Respectfully submitted,

E. W. GEHRING, *Treas.*

The report of the Treasurer was accepted and ordered placed on file.

PRESIDENT — I want to say just a word expressive of the feeling of the Dean of the Faculty of the Maine Medical School in regard to the Association's scholarship. I haven't seen Dr. Thayer smile as he

did when I told him about this scholarship, in a good while. He seemed to appreciate a great deal that we had made a scholarship for the school. I think that is about the best thing we have done in these meetings. I think now the question is whether one hundred dollars is going to be enough for us to do for the school. Here we have three thousand dollars in the treasury. A man can go to New York and stay a month — if he don't go down to Pabst's too often — with a hundred dollars. Now do we want to raise that amount say to two hundred dollars, or is one hundred all we can afford to do?

DR. PETERS — I should like to ask the Treasurer a question and that is how the income compares with the expenses. Is our treasury depleted or increased each year?

TREASURER — My impression is that the figures have been about the same. Perhaps there has been an increase in membership this year. The largest item was the amount paid to the Medical Journal, and in spite of that, we have more in the treasury. Not all the various county treasurers have been prompt in sending in their money. This report should include four hundred dollars more than it does. I closed these books the first of June, and the money is supposed to be paid in the first of the year, but this year there were delinquents amounting to four hundred dollars, which, if that were included, would make our balance just that much more than it shows on the report today.

DR. PETERS — Then we are taking in a little more than we are spending each year. We have laid out a plan that we hope will bring us in more money than we have previously had. If we are sure of paying expenses out of the income, we cannot afford to be too generous, I suppose.

PRESIDENT — The Association used to pay for an annual dinner which amounted to anywhere from six to seven or eight hundred dollars and that used to drop the balance down considerably. Just now, we have a lot of money on hand and we are going to have more. This State Association is going to grow; we have almost seven hundred members at the present time and we are growing all the time. We have increased our membership about seventy-five this past year, and I don't think after the enthusiastic meetings we had yesterday and last night that we shall lose many members. I think the trouble is going to be that we will have to look pretty carefully after the County Societies. We must be sure to have the right affiliation between the County Societies and the State Association. The County Societies—a good many of them—don't seem to care much about the State Association. I think the County Societies have got to wake up and do some personal work. A membership of sixty and only twelve of that sixty present at a meeting is not right. I do not mean all the County Societies;

some of them have a larger attendance, but we have got to do something that will increase the interest in our County Societies. There are a good many things that can be done to make members come to an Association or society meeting. Nearly forty years ago, I had the honor of rejuvenating the Franklin County Society, and our members used to come from fifty or sixty miles around. We had one old man who used to come who was sixty or seventy years old, and he used to drive all day long in order that he might be there. I had the honor to read a paper at one of the meetings, before old Dr. Blake — he was the head of the medical world there for fifty or sixty years — he was an old man, probably some eighty-odd years old. He sat and heard my paper through, in which I advocated that ether should be used to make the pain of labor less. Dr. Blake then got up and said he hoped the remarks of the young member would not be taken too seriously, for said he, "I have put forty-six hundred women to bed, and I never gave ether but four times and those women all died." That settled it.

There is as much enthusiasm in the County Societies as ever, if we can only get it to work, but the influential members of all these Societies, most of whom are present here, have got to work the whole Society up. Perhaps it was unavoidable — perhaps a good many of the members stayed away because the State President was going to be there — but it took a good deal of time to go — all night traveling to get there, and then to find only about five or six men present, it was, I admit, a little discouraging.

Now let us start in this year and try to wake up our County Societies. If we can get big County Societies, we can get a big State Society. We ought to have more than half the members in the State in this State Association which is the supreme medical body of this State. It is the mouth-piece of our medical profession in this State. The County Societies are the grammar school of the State, in medicine, and we shall not reach our best as a State Association until we get these County Societies all into line and all doing what they can to forward the interests of the profession in the State. I feel rather deeply about these County Societies and I want to see them grow as I know they can do when we each individually lend all the aid we are capable of doing.

SECRETARY — I have a communication here from the American Medical Association which I will read:

Dr. W. Bean Moulton, Sec'y,
Maine Medical Association,

Chicago, May 24th, 1912.

622 Congress St., Portland, Maine.

My Dear Doctor Moulton: — As Chairman of the Committee on National Department of Health, Dr. J. B. Murphy desires that your State Association

shall pass resolutions endorsing a bill to establish an Independent Public Health Service, now before the Senate, known as the Owen Bill, Senate Bill No. 1, and that through its officers, or a properly appointed and authorized committee, your Association shall urge the passage of this bill, and that arrangements shall be made so that one or two members will see the representatives and both the senators from your State for the purpose of explaining to them the benefits to be derived from this measure.

Kindly advise Dr. Murphy of the position these men hold with regard to the bill.

Very truly yours,

ALEX. R. CRAIG, *Secretary.*

DR. SPEAR — I am highly in favor of this bill but I did not know quite the best way to approach the matter perhaps. Men acquainted with the senators and representatives could perhaps do as much good as in any way, if they would make it a point to see them individually. I originally received a letter from the Medical Association asking me to see our senators and I intend to do so. I have not yet had an opportunity but I will gladly do so when I can and will endeavor to enlighten them as far as possible as to the situation.

DR. JACKSON — I was appointed by the American Medical Association sometime ago, perhaps at the same time Dr. Green was appointed, to do what I could in favor of this bill, and we have a good deal of correspondence between us, Dr. Green and myself, in relation to the matter. The question has been raised, I understand, that this is a sort of working trust or something of the kind, and that sort of idea is having a great deal of effect. Every quack in the country is writing and telegraphing about this so-called trust, and they have been able to create quite a favorable opinion, I understand, as regards their stand in the situation, down at Washington. We must do what we can to counteract that work. From the States of Washington and Oregon have come some very urgent letters and telegrams that went in there, telling their own story. Men have been appointed to create a great deal of unfavorable comment toward this bill on their side of the question, and if they create the impression at Washington that they are trying to do, that is to make it appear that nobody is to be employed regularly unless he is a member of the American Medical Association, it seems to me we have got to do a lot of work as a State Association to help to overcome this impression. We can get this bill through without a doubt if we all go for our State representatives and senators, but if we sit back and leave the work to be done by others, it will not get along very fast. There is no use in reporting the bill; that has been done and then it is simply shelved and that is the last of it. the question is are we ready to do all we can for the Owen Bill or not?

DR. SPEAR — When does it come up, Mr. President?

PRESIDENT — It has come up again and again but never seems to get beyond a certain point. Now we want to do what we can for it, see our senators and representatives and help the thing along as much as we can personally. We can all do a little something if we are willing to make the effort, it seems to me.

SECRETARY MOULTON — This letter simply wishes that we pass resolutions endorsing the bill. I think everybody is in favor of the bill and I think we ought to work for it, but the letter simply asks us to pass resolutions endorsing the bill. That is simply for the moral effect. I think we can at least pass these resolutions and then if the members of the Association can see the senators and representatives why of course that will help very materially.

DR. SPEAR — Why not send a copy of the letter to our representatives?

DR. PETERS — There is absolutely nothing that helps like a personal letter from each man to his representative. Unless you are dealing with a problem which is all bound up in politics, the personal letter is the thing that pushes it along; there is nothing that I know of so effective as the personal letter giving your own opinion about the matter and asking these men to use their influence in favor of the Bill. When a man gets fifty letters on one particular subject and all from people in his district, wanting him to do such and such a thing, they are going to sit up and take notice right away. It would not surprise me if something like fifty thousand letters have already been sent in on this subject — all these people have been writing the legislators for some time, and they have gotten their farmer friends more or less worked up about it, too, and I think if we can call the attention of the General Assembly to it sufficiently that twenty-five men will sit down and write a personal letter — men who are members of our Association — I think if we will do that it will be more effective than all the resolutions we can pass or all the talking that will be done on the subject. It is the personal letter every time that gets the attention of the representatives and these men at Washington.

DR. SPEAR — Would it not be a good idea to send a copy of that letter to the County Societies and ask the members there to sit down and write to their representatives personally and ask them to work for the Bill?

PRESIDENT — I will bring this matter up in our General Assembly meeting and I would like to have you gentlemen speak about these two matters you have just brought up here. I would also like to have someone write a resolution embodying those ideas—that is, the personal letters from our members, and the writing of letters by the County Societies, or one joint letter from the County Society, signed by

the Secretary and endorsed by the members. Will somebody write out the resolution and let me have it to read to the General Assembly.

DR. SPEAR — I think Dr. Peters could do that better than most any of us. He has expressed just the right idea, I believe.

PRESIDENT — I will appoint Dr. Spear and Dr. Peters and they will give me the resolution bye and bye.

SECRETARY — I have a report from the visitors of the Maine Insane Hospitals.

The report in full follows:

Your committee beg leave to report that on June 4, 1912, they visited the Maine Insane Hospital at Augusta and the Eastern Maine Insane Hospital at Bangor, and in so doing passed a most agreeable and instructive day.

The Hospital at Augusta is cared for and maintained in a most sanitary and hygienic manner. Three of the old stone wings yet remain to be renovated and modernized. It is now hoped that one may be so treated next year. As soon as all three are done the physical conditions of the Hospital will be excelled by none. At the time of our visit there 911 inmates — the full capacity of this institution.

Treatment of the insane has been progressing apace in the last few years, the most noticeable improvement being the almost complete elimination of restraint with any of the patients. Some of the wards are allowed to remain entirely unlocked throughout the day time. Certain patients who have been restrained for years are now allowed to go and come almost at will. Another progressive movement has been the introduction of trades into the institution, such as the manufacturing of stockings, broom-making, etc. A large number are employed on the farm doing general farm work, in the blacksmith shop and like occupations. In this manner a very great many become self-supporting; patients who have been shut up for five or ten years are now doing a full day's work every day.

Hydrotherapy is practised to a considerable extent in certain cases, and very few medicines are used. The Hospital maintains a training school for nurses, which is a most excellent step in the right direction. Dr. Miller has recently established a pathological laboratory and a start has been made in pathological research. It is along this line that progress in psychiatry must be looked for.

The Hospital at Bangor is arranged and cared for in a most modern manner. There are at the present time a few more than five hundred inmates. The sleeping apartments are arranged on the dormitory plan this having proved to be much more hygienic and convenient for the patients.

The treatment of the inmates of this institution are along the same line as in the one at Augusta — the elimination to a very large extent, of restraint, certain of the wards not requiring any night watch at all. Patients are kept occupied, as much as possible, by labor of various sorts.

The pathological laboratory and autopsy rooms are most excellently located and equipped for the carrying out of their purposes and twenty autopsies have already been made this year. A vast amount of most interesting material has thus been acquired, and the physicians, Dr. Hills, Dr. Tyson and Dr. Thompson are making the most excellent use of the same.

Here has been established a pavilion for patients suffering from tuberculosis, which accommodates about forty inmates, comprising most of the tubercular

patients from both institutions. The pavilion is admirably located on the south slope of a hill and good work is certainly being done there.

In conclusion, we would state that most excellent work is being done at these institutions, by the physicians in charge, but it seems to the committee that there should be a larger number of physicians at each Hospital in order to carry out the best possible treatment and investigation of the unfortunate insane, who are residents of the State of Maine.

Respectfully submitted,

PHILIP H. S. VAUGHAN,

RICHARD H. STUBBS.

The report was accepted and ordered printed in the transactions.

PRESIDENT — We ought to have a report from the Medical School of Maine. I am trying to get all this business finished and out of the way so we can go on the clam-bake early this afternoon.

DR. CAMPBELL — Mr. President, I would like to ask if it is within our power to change the amount of that scholarship, or if we simply leave it as it is to be acted upon when it gets around to the General Assembly.

PRESIDENT — The report has not been made on the address and the committee are going to report favorably. I think a hundred would do well enough to start with and then if it seems to work pretty well, why the Association can very easily increase it if it is desirable. If I was rich enough I would make it in my own name and have it handed down, but I am not rich enough to afford it, I am sorry to say.

I would call your attention to the fact that we have two councilors to be elected, one for the first and one for the second district. That might as well be taken up now and gotten out of the way.

DR. WING — I would like to make a suggestion if it is in order to say something about or in regard to bringing about legislation in regard to compulsory medical examination in our schools. I would like to know what action can be taken, or has there been any action taking looking toward this matter?

SECRETARY — I think perhaps Dr. Gehring knows more about that than a good many of us. Perhaps he will explain what the system is here.

DR. GEHRING — I know something about what the system is here. In the large cities of the State, it is to have medical examination of the school children, but I don't know to what extent that examination may be said to be compulsory, that is if a parent absolutely objects to it. I don't know that that parent can be obliged to have his child or children examined. The system we have here is simply this. The children are examined and referred to their family physicians, if anything is found to be abnormal, with the recommendation that the

condition be at once attended to. I do not think our system of examination is really compulsory, I hardly see how we could do more than we are doing and that is, where there is no real objection we examine and recommend as I have stated. The medical examiner will not treat a child unless requested—he does not treat the children, that is he does not prescribe for them. He simply recommends to the parents that the child be taken to the family physician for examination and such treatment as he, the family physician, may find necessary.

CRANE—I can say that in my town we have four examiners appointed every year and each man is paid two hundred and fifty dollars, and he is supposed to see the pupils three times a year. At first when we started this compulsory examination, we had more or less trouble and had to handle the matter with gloves, so to speak, for a while, but gradually we got the thing straightened out and now it works along very satisfactorily. If there is any trouble comes up we refer the matter to the family physician and that takes care of a lot of things.

DR. DICKINSON—The doctor spoke of compulsory examination. We have got compulsory examination in a good many places—here, I believe and in Bangor and in some of the larger cities, but what I understood the doctor to mean was compulsory school examination all over the State. In our town we have not got any school examining board—I believe the law says that we shall have them but this law is not compulsory and I don't hardly see how it could be. If it is compulsory in one portion of the State, it must be in all portions, which it is not at the present time.

PRESIDENT—Has anyone anything further to say on Dr. Wing's suggestion?

DR. SMITH—I regret to say, gentlemen, that I am a little tardy in appearing, but it was unavoidable, and I want to say just a word regarding the Owen Bill. When I was appointed on the Legislative Committee of the American Medical Association, they asked me to simply do what I could to get endorsement here in Maine to the Owen Bill, and your President tells me the matter has been taken up and I have no doubt it has been treated in the proper form, and I only want to be sure it is carried through. I meant to have been down here earlier, but if this matter has been attended to it is all right, but that is my business in coming down here this morning.

It was moved and seconded that the House of Delegates adjourn, and a meeting of the Council was announced to immediately follow the adjournment.

Adjourned.

W. BEAN MOULTON,

Secretary.

General Meeting.

MORNING SESSION.

June 13th, 1912.

The meeting was called to order by President Warren, who called upon Dr. Owen P. Smith to address the members relative to the Owen Bill previously discussed in the House of Delegates.

DR. SMITH — This matter has been referred to me as a member of the Legislative Committee, and it is a matter of very great importance, not only to our own State but to every State in the Union. It is as our President has already stated, in relation to the Owen Bill that I wish to speak, which Bill is now before the United States Senate.

The House of Delegates has recommended that the Society send to Washington today, this telegram:

"The Maine Medical Association now in session most heartily approves and emphatically urges the passage of Senate Bill No. 1, known as the Owen Bill, providing for the establishment of an Independent Public Health Service, and respectfully urges you to ask our senator to use every effort possible to further its adoption.

STANLEY P. WARREN, *President.*"

I would like the approval of this Association to this telegram so that it can be sent to Washington with your sanction and sent by your President. I would also like for this Association to have appointed the following gentlemen as a committee to get an editorial into every newspaper or into every paper in Maine, where there is a chance, clippings to be forwarded to our two senators, showing the sentiment of the people in Maine in regard to these matters. I would also like an opportunity this afternoon or sometime today when a full house is present, to request every member of this Association to write a personal letter, and if in your community there are any influential men who are interested in public matters, go and see them and urge that they write a personal letter to the senator in Washington. This matter is of great importance: the principal point of the bill is to take out of the Department of Agriculture the work of chemistry and put in a public health department in a separate bureau. The loss to this country of Dr. Wiley because of his inability to get any legislation through the political obstructions, which so handicapped and discouraged him that he resigned the position, was a great one — perhaps greater than many of us realize at the present time, but if we can have a public health department in Washington, that will bring this public service up to be a matter of great value to the American people, and I would like the action taken here in this assembly that I have indicated.

PRESIDENT — Gentlemen, you have heard the report of the Committee of which Dr. Smith has acted as mouth-piece, on the Owen Bill. I will read the telegram once more to you, and I think the time will come, and that that time is not far in the future when such things will be prohibited by law and we will not have these political obstructions.

Telegram read.

DR. GORDON — I would like to ask Dr. Smith if this list of names which he has arranged contains the regular nominee on the Legislative Committee from each county.

DR. SMITH — They are not altogether, I think. They have been selected from towns where there are newspapers because we wanted to get as many editorials into the newspapers as it was possible to do.

DR. GORDON — There is a committee in each county now.

DR. SMITH—These have been selected mostly in newspaper towns and with the help to be gotten from the newspapers in view. I will read the list as it stands.

Owen Smith of Portland.	Jackson of Houlton.
Crane, Bangor.	Haskell, Lewiston.
Campbell, Augusta.	Bunker, Waterville.
O'Connor, Biddeford.	Marston, Bath.
Spear, Rockland.	Webber, Calais.
Wakefield, Bar Harbor.	

DR. JACKSON — Part of these men are the Committee appointed by the American Medical Association, and some of these others have been added, a part of their business being to get that editorial.

DR. GORDON — I would like to ask some member from each county if they will designate the member of the Legislative Committee from that county and tell us if he is still living, or anything about him. Has there been any change in the Legislative Committee so far as you know?

DR. CUMMINGS — I will say that so far as Androscoggin County goes, I brought this matter before the County Association but I couldn't get them to vote on it, and when my County Association won't uphold me I just gave the thing up. Some of them had some objections to offer and so I simply decided that when my County Association would not uphold me, I would not have any more to do with it.

DR. GORDON — You are a member of the Legislative Committee from Androscoggin County?

DR. CUMMINGS — Yes, sir.

PRESIDENT — I will ask you to listen to the reading of the resolutions in favor of a State Board of Charities, by Dr. Jackson. This is a resolution that has been drawn up for our adoption and it is the result of the remarks made at our banquet last night by Robert Treat Whitehouse.

“Resolved, That it is the belief of the members of the Maine Medical Association that the creation of a State Board of Charities and Corrections of an advisory character, which should inspect and advise as to the management of all charitable and correction institutions, including medical and surgical hospitals, which are in any way aided by public funds, would be for the best interests of the State of Maine. and that any appropriate measure presented to the next Legislature to accomplish this purpose should receive the hearty endorsement and support of this Association. Such a Board would, we believe, effect a large saving of money for the State and would, through its members and skilled and experienced Secretary, become a central source of authority and information from which to instruct local trustees and enlighten public sentiment, and would assimilate and co-ordinate knowledge of such institutions and conditions, and tend to raise the poorer to the standard of the better, correct abuses on the one hand, and protect trustees and managing officers from unjust criticism, on the other hand. It would tend to eliminate politics from the management of State Institutions, and secure equitable appropriations between the different institutions, and prevent constant lobbying against each other, and would enable the citizens of Maine to know through an impartial, unbiased, unprejudiced Board how nearly half of the public moneys of the State are expended, whether with economy or waste, modern or antiquated methods, and faithful service by officials or otherwise. And finally, that such a Board would enable the State of Maine to take its proper position with the other twenty-one leading States of the Union which now have Boards of a like nature, and enable it to develop its charitable and correction institutions intelligently and along the lines of a symmetrical plan, having unity and consistency, and in line with modern thought and progress in charitable work and philanthropic endeavor.

PRESIDENT — The resolution is now before you for action and the Chair will entertain any remarks in regard to the matter.

DR. GORDON — I would like to say a few words on this subject. I have been considerably interested in the matter of a Board of Charities and have lost no opportunity to urge such a step should be taken. There is an absolute necessity for such a Board of Charities and has been for quite a considerable time, and the need does not decrease as the years run along. I am now connected as President of the Board of three institutions of Maine, The Insane Hospital, The Eastern Maine Insane Hospital and the School for the Feeble Minded. There are six democrats on that Board and one good strong Republican woman. We have had, of course, more or less in the way of political propositions put up to us, but I think I can assure you that those six democrats don't know whether it is a Republican superintendent or a Republican employee, or whether these people are Democrats in any

of these institutions, so long as they do their work and do it well, and I can further assure you that so long as those six men are members of these Boards of Trustees, no amount of political pull or political influence will in the slightest degree vary our course in the conduct of the business of those institutions for each one of us will listen to no political talk, nor will we allow ourselves to be swayed by any political opinion or influence. But we will bear watching just as much as other people, and while it is said that every man has his price, mine is high and I don't think any one will touch it for some time yet, and I feel as sure of the other five men as I feel of myself. But in times past it is a fact that politics has more or less ruled the Board, perhaps as much as anything else in the State of Maine, and certain propositions have been put up with that have certainly been harmful to our institutions. I believe a Board of Charities to act for us as specified in this resolution would be a great benefit to our State, whether the men in charge of the institutions are Democrats or Republicans — that makes no difference. I certainly urge the adoption of the report of this committee.

Upon motion duly seconded, the resolution was unanimously adopted.

DR. JACKSON — I would like to suggest one thing in connection with the adoption of this resolution, and that is that we do not simply adopt the resolution and leave it right there with this Assembly, but that some measures be taken by which the next Legislature shall know our opinion and know that this Medical Association is interested in the matter. It seems to me we ought to have some representative committee to see to it that the matter is brought prominently before the next Legislature. How can we bring it about best that our interest in this matter be brought to the attention of the next Legislature.

DR. GORDON — I have perfect confidence in the Legislative Committee of this State Association. I believe they will, or at least a large majority of them will be in favor of this matter, and therefore rather than to continue to multiply our committees, I move that this matter be committed to our Legislative Committee.

DR. JACKSON—Thank you, doctor, that is just about what I wanted, so as to be sure it would get to them and that they would bring out our position in the matter.

Upon motion, duly seconded, it was voted to leave the matter in the hands of the Committee on Public Policy, of which Dr. Gordon is Chairman.

The resolution favoring "Good Roads," prepared and read by Dr. Campbell of Augusta, before the House of Delegates, was now read to the General Assembly, and unanimously accepted.

PRESIDENT — The first paper to be presented this morning is on "Chronic Lead Poisoning from Drinking Water," by Dr. Stewart of South Paris. Dr. Stewart, gentlemen.

Dr. Stewart reads paper.

The next paper is on a very important subject, "Cancer," and is by Dr. Donald Cragin of Waterville. Dr. Cragin, gentlemen.

Dr. Cragin reads paper.

PRESIDENT — We will now listen to the report of the Committee on the President's address.

DR. BENNETT — Mr. President, your Committee appointed to consider the President's address, has attended to its duties and beg leave to report as follows:

1st. We hereby endorse the address as a whole.

2nd. We recommend that this Society exert its influence toward securing medical inspection of our public schools, which will only be effective when it is compulsory.

3rd. We recommend that the Maine Medical Association place itself on record as being in favor of more satisfactory control of child labor.

4th. We heartily agree with the President in reference to his suggestion regarding a Visiting Committee whose duty it shall be to attend each of the County Societies, and by co-operation with the county members, do all in their power to increase the membership and improve the work in said Societies.

5th. We recommend that the suggestion regarding a scholarship in the Medical School of Maine be adopted, and one hundred dollars appropriated for that purpose.

6th. In this able and practical paper, we believe there is no more important suggestion than that referring to the advisability of each county or union of counties to provide hospital accommodations for its tubercular citizens. There is, at present, no provision, on a large scale, in this great State for the *poor* tubercular patient, and the vast majority of these people are poor. We heartily endorse the plan proposed.

Respectfully submitted,

DOCTORS MASON, WILLIAMS AND BENNET.

The resolution favoring State roads read by Dr. Campbell to the House of Delegates, was then read by him to the General Assembly.

PRESIDENT — The next matter to come before the meeting is the paper on "Small-pox," written by Dr. E. T. Flint and to be read by Dr. Marsh.

DR. MARSH — Mr. President and members of this Association, this paper was prepared by Dr. Flint of Dover. On my way here to the convention I met Dr. Flint and he asked me to take his paper to the Association and present it to the Committee on Programs, which I did, and they requested that I read the paper. Now if I make many mistakes, you will please bear with me, as this is the first time I have read it to learn its contents.

PRESIDENT — We shall meet at two o'clock this afternoon as nearly as I can get here. Some very important matters will come before us this afternoon, and we want to get the business over as soon as we can.

On motion it was voted to adjourn until two o'clock in the afternoon.

Adjourned.

W. BEAN MOULTON,
Secretary.

General Meeting.

THURSDAY AFTERNOON.

June 13th, 1913.

PRESIDENT — I would suggest that the members of the Council meet immediately in the Aldermen's room and attend to their duties. This is our last session and we want to complete the business as soon as possible.

The House of Delegates have two members of the Council to elect and it would be well for the House of Delegates to attend to their duties also. If there are members of the House of Delegates present in this meeting, will they meet in the small committee room adjoining and attend to their duties.

We will now listen to the report of the visitors to the Medical School of Maine:

The report follows:

Gentlemen of the Maine Medical Association:

Your Committee appointed to visit the Medical School of Maine beg to submit the following:

The teaching force of the Maine Medical School has been greatly enlarged from former years. In the annual catalogue of 1910-11, there were twenty-seven professors, assistants and instructors, while in the catalogue of 1911-12, there are fifty. Owing to the illness of Professor Witherlee, Professor of Neurology and Mental Diseases, lectures have been given by Dr. Swift of Massachusetts. Dr. Miller, Superintendent of the Insane Asylum at Augusta, has given clinics at Augusta for the benefit of the students, which were very interesting and instructive.

Prof. F. P. Webster has given, during the last year, his first full course of lectures on diseases of children. I think it is not generally known by the

profession that in order for physicians to be able to register in the City of New York, they must be graduated from a Medical School in which there are at least six full professorships, where the men do nothing but teach. This would exclude, until the present time, any man desiring to register in New York, who was an alumnus of the Medical School of Maine.

By a re-arrangement of the curriculum this difficulty is overcome and the matter has been arranged to that end. These professorships will include the instruction of the first and second year men at Brunswick. Some of the small medical schools of the country cannot conform to this condition and will of necessity be obliged to relinquish their charters. The Medical School of Maine and Bowdoin College are to be congratulated, that they are able to conform to this new requirement.

All medical schools require students to dissect one-half of a body, but the present class has been able to dissect every part of one body.

By arrangement with the Boston Lying-in Hospital, it is now possible for students at this school to go to Boston and have full charge of at least six cases of confinement, under competent instructors, without cost, except for board while attending the course.

Hon. Hugh J. Chisholm, a rich philanthropic citizen of Portland, has given a lot and is now building a large dispensary for the benefit of the worthy poor of Portland, and for clinical teaching in the Medical School, at a cost of about \$30,000.

Free dispensary treatment will be instituted at the completion of the building, and every branch in the teaching force of the school will be represented at the clinics which are to be held daily.

The course of instruction given at this school under Prof. F. M. Whittier, cannot be praised too much. Bacteriology, histology and pathology are better taught than in any small college in New England, and all students taking the course are well grounded in these most important branches. The sympathetic and co-operative spirit so universally manifest in Prof. Whittier's classes, are very noticeable and very pleasing to observe.

The instruction throughout the school is thorough and up-to-date and careful observation shows that men who graduate from this school are successful in more than an average degree, which speaks well for the teaching force. The final oral examinations showed that the students had grasped the subjects well, and all of the young men acquitted themselves with distinction, showing comprehensive, practical and thorough instruction from all of the faculty.

Your committee desires to thank the various teachers in the school for the many courtesies received.

Respectfully submitted,

EDWIN M. FULLER,
A. L. STANWOOD.

PRESIDENT — Dr. Gerrish has a brief report to make. We will now listen to him.

Mr. Chairman and Members of the Maine Medical Association:

This is a brief report which I will make as a delegate to the Conference of the Council on Medical Education of the American Medical Association.

By the desire of the President, I attended the educational meetings in Chicago, in February, 1912.

The most interesting feature of the Conference was the address of Mr. Frederic G. Hallett, of London, England, on "The Organization and the System of Examinations of the Conjoint Examining Board of the Royal College of Physicians of London and the Royal College of Surgeons of England." Mr. Hallett came to America by invitation of the Council for the purpose of giving this address, which he of all men was the most competent to prepare, as he has been the Executive Officer of the Board for a long time, and has had much to do with the development of the system, which seems to be the best possible at the present time. The feasibility of combining the practical with the more usual methods of examination was clearly demonstrated and the discourse was most instructive and stimulating. No abstract is here attempted, inasmuch as the paper has been published in full in the Journal of the American Medical Association, and is thus accessible to all.

Our school continues to be ranked by the Council in the first class, where it will doubtless remain, in view of its compliance with the exactions of the most advanced requirements.

A few years ago the school deemed it advisable to adopt the curriculum prescribed by the Association of American Medical Colleges, and has been working on this line for sometime. Having qualified itself in every direction for membership in the Association, it applied for admission. More intimate observation of the workings of the organization, however, convinced the school that the advantage of this fellowship had been overestimated; and, consequently, the application was withdrawn before the executive council took action upon it. The school is persuaded that it can work more advantageously and obtain better results, if unhampered by the dictation of an irresponsible and untrustworthy body.

FREDERICK HENRY GERRISH.

PRESIDENT — The final paper on the program is by Dr. Philip W. Davis of Portland, and Dr. Davis' subject is Obstetrics. We will now listen to Dr. Davis.

Dr. Davis reads paper.

PRESIDENT — The next business to come before the meeting is the election of officers.

DR. PETERS — Mr. President: Several of my friends are prepared to present my name as a candidate for President of this Association. I happen to know this; they told me so. It is certainly a great honor to have your name used for the purpose of being elected to the highest office this Association can confer upon one of its members. Certainly, if the Nominating Committee should ever offer me this honor when I thought I was justified in becoming a candidate, I should be very much pleased. But that time is not now. This, however, is the time when the Association should stand absolutely together on all subjects, as a unit. There are a great many questions to present themselves which are of vital importance to the medical profession. You know them as well as I do, and therefore, this is the time when we should be absolutely united. I wish to take this opportunity to thank the men who have considered me for this high office and this great honor, and I also

would like to take the opportunity I now have of presenting the name of Dr. R. H. Marsh of Guilford, as the candidate for President of this Association.

DR. GORDON — I second the nomination.

DR. JACKSON — Dr. Marsh has been one of our Councilors for the last three years; he is a man whose interests are devoted to this Association and it gives me great pleasure to second his nomination.

DR. HUNT — Being from Piscataquis County, I take great pleasure in seconding the nomination of Dr. Marsh as President of the Maine Medical Association. Dr. Marsh has always been faithful and energetic in the work of the County Societies and has spent not a little time in visiting the County Societies and giving them such encouragement as would come from his visits. From the way he has handled matters in his own county of Piscataquis, I feel sure he will bring much added strength to our Maine Medical Association when he takes up the duties of President.

Dr Gordon moved that the Secretary be authorized to cast the ballot of the Association for Dr. Marsh, and the same was accordingly done, and Dr. Marsh was declared duly elected President of the Maine Medical Association.

PRESIDENT WARREN — It gives me great pleasure to present Dr. Marsh to the Association, as the President-elect.

PRESIDENT MARSH — Mr. President, and Gentlemen of the Association: I thank you very much for the honor you have conferred upon me this afternoon, and I will try to the best of my ability to serve you in this capacity.

DR. GORDON — Mr. Vice President and Members of the Maine Medical Association: I think we are all willing for the name of the Maine Medical Association to do a great deal of work. A large number of new members have been brought in this year, we have increased our enthusiasm. Plainly, our President, Dr. Warren, has labored faithfully in our behalf. At great trouble and expense he has visited the various County Societies; he has given us his aid and his counsel in every way possible, and I think we can safely say we have had one of the best sessions of meetings we have ever had. I am sure that lecture by Dr. Cragin was well worth coming here for, if we had heard nothing else, which we have. Gentlemen, I move you a rising vote of thanks be given our retiring President, Dr. Warren, for the way he has taken care of us this year, and the way he has attended to the matters of the Maine Medical Association.

VICE PRESIDENT PETERS — I can think of nothing that would give me more pleasure than to present this motion to the House.

The motion was unanimously carried.

PRESIDENT WARREN — I thank you, gentlemen, for so kindly receiving the efforts I have been able to carry on for the success of this meeting. I don't accept them so much for my colleagues in the administration of the affairs of the Association, as for myself personally, I consider this the highest honor of my life, and if nothing else happens and my life ends to-morrow, I am perfectly satisfied. I had a pretty hard time here a short time ago, and I came out of it, and now if it ends here, I will find no fault, but say, I will be satisfied. I have been allowed to finish out the work of being President of the Maine Medical Association.

PRESIDENT WARREN — There are a few matters of unfinished business to come before us, such as the question of medical charities, the medical defense fund and also the matter of contract and lodge practice, the continuation of the Journal and one or two other matters. I will ask Dr. Gilbert to present the questions embodied in Committee's Report.

DR. THOMPSON — I move that the report of Dr. Gilbert be read by title for the purpose of saving time. Simply put the report in and then we can act upon it.

PRESIDENT — As I understand it, it is this: We are to act upon the different items of this report, it having been discussed before the County Societies. First, we will take up the question of a medical expert. What is it deemed desirable to do in this case?

JACKSON — It has been suggested that we act jointly with the State Law Association on this matter. In Rhode Island, they have been trying to get some law upon both the medical and legal profession and have it passed at the next session of the Legislature and placed on the statute books.

It was moved and seconded that the section be adopted and the same was unanimously done.

PRESIDENT — Section 2. Commitment of the insane — A Voluntary Admission Act. 6. Emergency admission to insane hospitals. What will you do with this section, Gentlemen?
with this section, Gentlemen?

It was unanimously voted that this section be adopted.

PRESIDENT — Medical defense. This is the matter of creating a medical defense fund to be composed of the council or a representative from each county, this fund to be used for the protection of members of the Association when necessary. The object being to give the men a better value for their membership and on the other hand to bring in a larger membership into the Association and so strengthen our organization.

DR. GILBERT — All the Editors of the various State Journals tell me that the reports that they receive are uniformly in favor of this defense fund; only one State reports bad results and that was for one year and it was the State of Iowa. Kentucky had eighteen cases, the cost of which was practically \$120 per case. New Jersey had an average of \$250 to \$350 per case — that was the highest cost. Several others, uniformly light at first, thought the cost might not increase greatly, but sometimes they do increase and sometimes they lessen. It is a help to the country practitioners — a sort of protection that the men appreciate.

DR. ————— — All the Editors of the various State Journals tell Society to adopt this section. Suppose a man is insured and has a suit brought against him and notifies his insurance company and they request that the matter be left in their hands. Some did not seem to understand just what the benefit would be that would be derived from it, and thought that inasmuch as the members were protected by an insurance company that that ought to be sufficient, as it probably would be for a good many of the members, who would prefer to handle matters that might come up in that way. Doubtless that is true of a good many of our members throughout the State.

DR. GILBERT — I think probably the medical defense fund and the insurance defense would handle entirely different matters; I don't think one would embarrass the other in any degree. I think perhaps our city members would not value this defense fund as would the country practitioner who will be greatly helped if such a fund becomes available. If a man had another insurance which he could fall back upon in case a defense fund was necessary, he would leave the matter to the insurance company to be adjusted by them. This fund would not in any way conflict with the insurance one might have in cases where defense might be necessary. This is an entirely different matter, and simply adds one more value to the thing our members outside of city limits think themselves assessed for. Most of them think they are not getting as much as they ought, and this defense fund offers help in case suits are brought against them. It will, I believe, materially help out our membership eventually, and it will materially help the man who is located in the country districts.

DR. PETERS—It has two faults; one is that it does not tend in any way to put a draw upon the doctor, who may even though a member of our Association, be found doing something which we would know to be unjust, and I don't see how this would help us much. There ought to be some way that some weight could be brought to bear. I believe that in Penobscot County, if we increased the dues one dollar for any

reason, we should lose some members, and I would like to ask the other Penobscot members who are present, if they don't agree with me.

DR.——— That would increase our dues a dollar a year and we have about seven hundred members. That would give us seven hundred dollars more than we have now. It don't seem to me if we had many suits that that amount would anywhere near cover it. Ever since I have been in practice, I have carried an indemnity insurance and I never have had the least trouble because of it. They charge me ten or fifteen dollars, and if it costs that to insure one man, I don't see how you could go much further and only charge them a dollar apiece, taking the members indiscriminately.

DR. GILBERT — No matter how much money might be raised in this manner — it is not to pay the costs that may be taxed against any defendant in our courts. The idea is that an attorney is to be employed by the Association whose business it shall be to take hold of the case of a man when it is brought to him and put it in shape, so that it can be presented to the judge. There are no damages to be paid by the Association for any suit which might be brought against any of our members. You are simply getting the services of an attorney to prepare your case for trial at the expense of the Association, that's all.

DR. GORDON — I do not believe that the game is worth the candle. This is increasing the dues of the members to five dollars in all, and that is quite a little tax with all the other taxes that necessarily come up to many of us. I suppose if I had a case where it was necessary to have a lawyer look into the matter, I should very much rather have my own lawyer attend to it for me than anybody else, and I should be willing to pay him for doing the work, and I believe almost any man in this Association would do the same; that is, that they would rather have their own lawyer than to have one employed by the Association. We should be obliged to have our own lawyers afterwards, and I think it would be just as well if we do not make two bites at the same cherry. I move the matter be laid upon the table.

It was so voted.

DR. GILBERT — The next matter is that of our State charities, the recommendation of the formation of a State Board of Charities, with representatives in each county who will investigate charity cases.

The next is that hospitals receiving State aid, shall not admit to private rooms patients receiving free medical and surgical services.

DR. PETERS — Will that in any way conflict with the resolution along these lines passed this morning?

DR. GORDON — That was another point this morning. I move that this last proposition be divided. I move the adoption of the first part relative to a Board of Charities.

PRESIDENT WARREN — It is moved that the second section be divided and that the first part of the section be adopted. Are you ready for the question?

The motion was unanimously carried.

PRESIDENT WARREN — The second portion, hospitals receiving State aid shall not admit to private rooms, patients receiving free medical and surgical services. This is made a section by itself. What will you do with it?

This section was unanimously adopted.

DR. GILBERT — Fifth: This is merely a recommendation to the County Societies that some action be taken on contract practice, which will prohibit members from taking cases at less than the regular fees.

DR. ——— I would like to bring up a question which came up in York County in regard to whether or not this prohibits men who are appointed city and town physicians from performing their work. Whether that comes under contract work. Of course they work on contract and some towns and cities are taken care of in that way, and what I want to know, is whether or not this would affect them.

DR. THOMPSON — This matter has been brought to the attention of the County Societies and committees have been appointed and these committees have the matter under consideration, and it seems to me that we should leave it as it is until the committees have investigated it in all its various aspects. I move that the matter be laid on the table.

PRESIDENT MARSH — I think the majority of the counties have recommended the adoption of that measure, with one or two exceptions.

DR. PETERS — I wish to say for Penobscot County, that this idea was adopted two years ago and has been enforced and found absolutely effective ever since.

DR. MARSH — This matter was voted on in the Androscoggin County meeting in March, all contracts to expire within one year.

DR. HAYES — I have been a member of the Maine Medical Association for a good many years and I have been handling contract for a good deal of that time and should dislike to discontinue my practice in that line, and yet this section would debar me from membership unless I did so. I could not continue as I am doing and be a member of this Association. The work I am doing is such that it is absolutely necessary to employ a contract surgeon. The men are going through a wilderness much of the time, and the employers are virtually obliged, in order to keep employees at distant points in the woods, to hire and bring them from a distance, and in order to keep them after

they get them, they are obliged to employ a contract system. I should want to know just where I stand in cases of that kind.

DR. CAMPBELL — I know in Kennebec County I investigated this matter very carefully. I am at present holding a contract position with the Edwards Manufacturing Company, but I am convinced it is detrimental to our profession, and I am willing to surrender my contract with the Edwards Company and conform to the general opinion of the members present, and I certainly hope that some action will be taken at this time. I have no doubt the Edwards Company would be willing to pay a physician the regular rates, but they say as long as other concerns can take care of their work for less, we feel justified in doing the same.

DR. THOMPSON — I am sure this matter is not fully understood. For a man who has no contract work, it is a very simple thing to say give up the contract work or leave the Society. Unless you drop this contract work you cannot belong to the State Association. That is not right. There are a lot of young fellows who must get a little bit of a hold and if they have a little contract work, it means something to them. Some of us may not appreciate this, and we may think we see the injustice of doing contract work. I am speaking for Cumberland County and we have a problem that is much greater in this line than that of most of the counties perhaps. We have all sorts of combinations here in Cumberland County, and I know, as President of the County Association, that some lines should be drawn, but I should object very strongly that any settlement of this matter be made for the County of Cumberland, until we are in a better position to see what is best. Personally, I shall strongly object to any outside settlement of this matter which belongs to us alone as a county, to settle. I appreciate the position of my brother who has spoken of his contract work, and we have some similar cases in Cumberland County. I move that the matter be laid on the table.

DR. GORDON — I have never done any contract work, and I hope I never shall, for I never have liked this system of regular lines of work with less than regular fees. Now are there any regular fees? I cannot find that out to my satisfaction. There are some men who are doing work for one dollar a visit and some for two, and you can't tell anything about it. I shall second the motion of Dr. Thompson.

The motion was duly carried.

PRESIDENT WARREN — Has the Council a report to make?

It was found that no extended report had been prepared, the report later coming by way of the Journal. The Council reported that the accounts of the Treasurer had been audited and found correct.

PRESIDENT WARREN — The last business to come before the meeting is the report of the Nominating Committee. This Committee will now report.

SECRETARY MOULTON — The House of Delegates has attended to all the routine matters and the following officers were duly nominated for the ensuing year:

First Vice President — T. E. Hardy, No. Vassalboro.

Second Vice President — J. M. O'Connor, Biddeford.

Treasurer — E. W. Gehring, Portland.

Secretary — W. Bean Moulton, Portland.

Delegate to A. M. A. — E. H. Bennet, Lubec.

Alternate Delegate — Stanley P. Warren, Portland.

Visitors Maine Medical School — F. E. Sincok, Caribou; W. F. Hart, Camden.

Visitors Insane Hospitals — Adelbert Williams, Phippsburg; G. M. Woodstock, Bangor.

Committee on Scientific Work — F. Y. Gilbert, Portland; T. J. Burrage, Portland; W. Bean Moulton, Portland.

Committee on Public Policy and Legislation — S. C. Gordon, Portland; C. C. Hall, Dover; Pres. and Sec'y Ex-officio.

Committee on Laboratory — Philip P. Thompson, Portland.

Committee on Necrology — J. A. Spalding, Portland.

Committee on Venereal Diseases and Their Prevention — F. N. Whittier, Brunswick; E. E. Holt, Portland; Addison S. Thayer, Portland; F. H. Jackson, Houlton.

Committee on Cancer — F. H. Jackson, Houlton; G. B. Swasey, Portland; S. F. Webber, Calais.

Councilor First District — J. D. Cochrane, Saco.

Councilor Second District — E. S. Cummings, Lewiston.

PRESIDENT — You have heard the report of the Nominating Committee; those in favor will please manifest it.

It was unanimously accepted, and the persons nominated were duly elected to the respective positions named.

PRESIDENT WARREN — Is there any further business to come before the Association at this time? We have completed everything, have we? Then the Association is the guest of the Cumberland County Medical Association on a delightful sail and clambake, the boat leaving the wharf as soon as we arrive there. Will somebody make the motion to adjourn.

The motion was duly made and seconded and the meeting adjourned.

W. BEAN MOULTON,
Secretary.

House of Delegates.

Alderman's Chamber, Portland, June 13, 1912, 2.30 P. M.

Dr. Bartlett of Norway was elected as presiding officer.

On motion from the floor, Dr. J. D. Cochrane of Saco was elected Councilor for three years for the First District, comprising York and Cumberland Counties.

On motion from the floor, Dr. E. S. Cummings of Lewiston was elected Councilor for three years to represent the Second District, comprising Androscoggin, Franklin and Oxford Counties, Dr. Bartlett expressing a desire not to be re-elected.

The following list of officers as suggested by the Nominating Committee and subsequently revised was declared elected, the Secretary casting the vote for the House.

First Vice President—T. E. Hardy, North Vassalboro.

Second Vice President—J. M. O'Connor, Biddeford.

Treasurer—E. W. Gehring, Portland.

Secretary—W. Bean Moulton, Portland.

Delegate to A. M. A.—E. H. Bennet, Lubec.

Alternate Delegate—Stanley P. Warren, Portland.

Visitors Maine Medical School—F. E. Sincock, Caribou; W. F. Hart, Camden.

Visitors Insane Hospitals—Adelbert Williams, Phippsburg; G. M. Woodcock, Bangor.

Committee on Scientific Work—F. Y. Gilbert, Portland; T. J. Burrage, Portland; W. Bean Moulton, Portland.

Committee on Public Policy and Legislation—S. C. Gordon, Portland; C. C. Hall, Dover; President and Secretary Ex-officio.

Committee on Laboratory—Philip P. Thompson, Portland.

Committee on Necrology—J. A. Spalding, Portland.

Committee on Venereal Diseases and Their Prevention—F. N. Whittier, Brunswick; E. E. Holt, Portland; Addison S. Thayer, Portland; F. H. Jackson, Houlton.

Committee on Cancer—F. H. Jackson, Houlton; G. B. Swasey, Portland; S. F. Webber, Calais.

Adjourned.

W. BEAN MOULTON, *Secretary*.

The Council.

Alderman's Chamber, Portland, July 13, 1912, 3 P. M.

Dr. Bartlett of Norway elected President, pro tem.

After hearing evidence from the Board of Censors of the Knox County Medical Society and from Dr. Coombs, the Councilor from the

Sixth District, it was voted that the action of the Censors in refusing membership to the physician applying for same be sustained.

The "Committee on Venereal Diseases and Their Prevention," and the "Cancer Committee" were voted funds not to exceed fifty dollars each.

The "Committee on Necrology," Dr. Spalding, was voted an appropriation for stamps and necessary disbursements.

The salary of the Secretary for the ensuing year was continued at \$200.

Dr. F. Y. Gilbert was re-elected Editor of the Journal and with power to appoint such Assistant Editors as he should see fit, along the lines followed out last year so far as they do not conflict with the resolutions adopted by the House of Delegates at the meeting of yesterday and the former appropriation was continued.

Dr. R. H. Marsh of Guilford having been elected President of the Association appointed W. C. Peters of Bangor to fill out his unexpired term as Councilor of the Sixth District, comprising Aroostook, Penobscot and Piscataquis Counties.

The accounts of the Treasurer, E. W. Gehring of Portland, were audited by a Committee consisting of Drs. Marsh and Wakefield and found correct.

Adjourned.

W. BEAN MOULTON, *Secretary*.

Annual Banquet.

The annual banquet introduced an absolutely new and, we hope, a lasting feature in the life of the Maine Medical Association. Few men have keener interest in the general welfare of the State than the medical profession, while all have grown to love their own State, particularly after having travelled through different parts of the country.

Following the banquet, Dr. William C. Peters of Bangor, who acted as toast-master at the Bar Harbor meeting, again served in a most efficient manner, introducing the various speakers in a pleasing way.

The after dinner speakers were Cyrus W. Davis, Secretary of State, who delivered a very classical oration on the "Good Old State of Maine." Governor Plaisted was invited but owing to previous arrangements, was unable to attend. "Welcome to Portland," by Hon.

Oakley C. Curtis, Mayor of Portland, was thoroughly sincere. Seth C. Gordon, one of the oldest members of the State Association, spoke in the behalf of "Our State Association," while Prof. George T. Files reviewed the present status of the "Good Roads" question which is near to the heart of all professional men.

One of the eminently important features was that taken up by Robert T. Whitehouse, Esq., United States District Attorney, who spoke briefly on the "State Board of Charities," and it is a notable and worthy fact to note that the Maine Medical Association unanimously adopted the resolution favoring the creation of a State Board of Charities in Maine.

Owing to the lack of time and the lateness of the hour, Rev. Raymond Calkins, merely expressed his delight at being present and the Association missed a most delightful talk along the lines of prison reform work. Dr. Calkins is a very active worker along these lines.

The last speaker on the program was Addison S. Thayer, Dean of the Faculty of the Medical School of Maine, who spoke on "Our Medical School." He expressed his appreciation of the establishment of a school fund founded by the State Association, also the various changes made during this year tending towards raising the standard of the school.

As before stated, this plan of having up-to-date, live issues of non-medical nature discussed by men familiar with subjects, marks a new innovation and we trust there was not a member present, who followed the list of speakers, that went away without learning something new. On the other hand, every effort will be made the coming year to restrict after dinner speakers to a ten or fifteen-minute talk and if necessary, lessen the number of speakers.

Future meetings of this kind will include the ladies.

Sail and Clam Bake.

Following the adjournment, the members were entertained as guests of the Cumberland County Medical Society by a sail down the bay to Long Island. Music was furnished by Chandler's First Regiment Band. A typical shore dinner was provided and a very delightful informal social evening ended the 60th annual session.

The number of registrations was 256, the largest in the history of the Association.

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Ladies' Reception.

On the afternoon of June 12th, a reception was given at Portland, from four to six, at the Lafayette Hotel, to the wives of the visiting members of the Association. The following invitation was sent to the ladies, whose husbands belonged to the Association, throughout the State:

Maine Medical Association
Ladies' Reception at the Lafayette Hotel
Wednesday, June 12, 1912
4 to 6 o'clock

The parlors and music-room of the hotel were tastefully decorated, and refreshments were served from a large, round table in the music-room, where music was furnished by a ladies' orchestra. The reception was quite informal and well attended, the ladies from out of town expressing much pleasure in being given the opportunity of meeting socially the wives of the Portland members.

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County News.

CUMBERLAND.

PORTLAND MEDICAL CLUB.

The November meeting of the Portland Medical Club was held at the Columbia, Nov. 7th, there being twenty-eight members and two guests present. The report of the outing committee was read and accepted, and the Treasurer ordered to make up the deficit shown. There were five applicants for membership, whose names were referred to the Board of Censors for approval. The committee for the annual banquet was elected to consist of Drs. Moore and Folsom, together with the Secretary of the Club. Dr. Driscoll reported a very interesting case of Melena of the New Born, in which cure was started by the improvised use of Diphtheria Anti-toxin in lieu of Rabbit serum, before the latter could be obtained.

The essayist of the evening was Dr. E. W. Gehring. Subject: "Question of Altruism and Egoism in Medicine." This exceptionally well-delivered paper was most interesting, very thorough, and in its conclusions of advising a fair admixture of both influences in the life of the practitioner of medicine received verbal support from the members present, the greater part of whom entered freely into the discussion which followed. In itself a very thoughtful paper, it stimulated the same process in the listeners, and for this is heartily to be commended.

General interest was taken in the proposal made, that perhaps Medical clubs in the city would be advanced by the amalgamation of this club with the County Society, but after lengthy discussion, no vote was taken on the matter, the majority clearly showing that such a step was not approved by them.

H. J. EVERETT, *Secretary.*

WESTBROOK MEDICAL CLUB.

The Westbrook Medical Club held the first meeting of the season with Dr. Louis L. Hills. Dr. Richard Small of Portland read a very interesting paper on "Obstetrics."

The following officers were elected: President, Dr. F. L. Ferren; Vice President, Dr. C. O. Haynes; Secretary and Treasurer, Dr. L. L. Hills.

LOUIS L. HILLS, *Secretary.*

KENNEBEC.**AUGUSTA MEDICAL CLUB.**

The November meeting of the Augusta Medical Club was held at the Augusta House at eight P. M., November 11th. Dr. W. S. Thompson entertained the members and in the absence of the President, occupied the chair. The attendance was small, many of the members being in attendance at the Clinical Congress in New York. Dr. H. W. Sampson of The National Home read a thoughtful and practical paper upon "The use and abuse of Digitalis."

H. W. MILLER, *Secretary.*

YORK.

At the Annual Meeting of the Sanford and Springvale Medical Association held Thursday evening, November 14, Dr. Louis W. Parady of Springvale was elected President, and Dr. Daniel W. Wentworth of Sanford was elected Secretary and Treasurer for the ensuing year.

***Alvarenga Prize
of the College of Physicians of Philadelphia.***

The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to about One Hundred and Eighty Dollars, will be made on July 14, 1913, provided that an Essay deemed by the Committee of Award to be worthy of the Prize shall have been offered.

Essays intended for competition may be upon any subject in Medicine, but cannot have been published.

THOMAS R. NEILSON, M. D.,
Secretary.

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PERSONAL NEWS AND NOTES.

Dr. H. E. Milliken of Portland, is at present located in New York City.

Dr. Henry M. Swift announces the opening of his office, 225 New Baxter Building, 665 Congress Street, Portland. Practice limited to Nervous and Mental Diseases.

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Three series of courses in Sanitary Science were started at Tulane this Session. These courses are for Medical, Science and Engineering students specializing in Sanitation. The Medical graduate in this course expects to become the Health Officer on Boards of Health; the Science graduate becomes the expert on Sanitary Biology and the Engineering graduate will eventually design, build and care for structures for sanitary purposes.

Among the Maine men attending the Third Annual Clinical Congress of Surgeons of North America were as follows: Drs. W. L. Cousins, John

Thompson, E. E. Holt, W. H. Bradford, H. F. Twitchell, A. H. Little, William Moran, Ernest Folsom, Stanwood Fisher, E. G. Abbott, H. A. Pingree, F. W. Lamb, F. P. Webster, E. E. Holt, Jr., F. Y. Gilbert, P. P. Thompson, James D. Clement, T. F. Conneen, Alfred Mitchell, Jr. of Portland; Drs. B. F. Sturgis and John Sturgis of Auburn; Dr. Bell of Strong; Dr. G. L. Pratt of Farmington; Dr. O. B. Head of New Sharon; Drs. T. L. Dickison, F. H. Jackson and F. W. Mitchell of Houlton; Dr. R. W. Wakefield of Bar Harbor; Drs. S. J. Beach, Wellington Johnson, George R. Campbell, R. H. Stubbs, A. H. Sturdivant of Augusta; Drs. L. G. Bunker, J. F. Hill, D. B. Cragin, F. C. Thayer of Waterville; Dr. T. E. Hardy of North Vassalboro; Dr. H. H. Crane of Bangor.

The sympathy of the medical profession of Cumberland County and the State are with Dr. A. S. Gilson of Portland, who is under treatment at Hebron Sanatorium. We all join in wishing him as speedy recovery as possible.

Dr. E. D. O'Neil and wife of Biddeford have returned from New York City, where Dr. O'Neil attended the Third Annual Clinical Congress of Surgeons of North America.

Dr. L. L. Powell of Saco gave an address on the subject of the anti-tuberculosis crusade, at the Foss Street Methodist Church, Biddeford, Sunday evening, November 2. The discourse was illustrated with stereopticon views.

Dr. J. A. Randall of Old Orchard, has been on a week's vacation lately, in Limington, his native town, and vicinity.

Drs. H. P. Merrill and G. I. Geer of Portland and A. L. Jones of Old Orchard, were among the number from this vicinity who attended the Harvard-Dartmouth football game in Cambridge, Saturday, November 16.

The Vanishing Man.

By R. Austin Freeman. Published by Dodd, Mead & Company, New York, 1912.

Some may say that a notice of a mere detective story is out of place in a Medical Journal, but every physician who opens the pages of this attractive work will follow it out to the very last with the feeling that here at least is a book in which every medical man can take an interest during a leisure hour, either in his office after the day's work is done or when traveling on the railroad to some distant patient.

For, here we have a great story told by a physician as the hero, and at once in addition to the vanishing of a well known man, we are attracted by the lovely romance which winds in and out around this physician's life. Next, the man who makes it his business from the startling vanishing of John Bellingham, to discover his whereabouts if anywhere on earth, is a medical lecturer, and additionally a new and distinct type of detective whose methods of keen analysis defy description and create a thrilling fascination whenever he comes upon the scene. Finally, although it is of course unfair to give the slightest clue to the plot of a story of this sort, yet in a general way I may say that every physician will value the outcome of the work as a distinct triumph and vindication of the values of the X-Ray, and of skiagraphs, in detecting one of the most remarkable "Vanishings" recorded in fiction. When the medical reader reads the account of the appearance of the X-Ray pictures of the *silver sutured patellae*, he will agree with me, that nothing more remarkable in the way of a scientific detective story has ever yet been written. Even without that telling triumph of medical skill, the book is worth reading from a romantic and literary point of view.

J. A. S.

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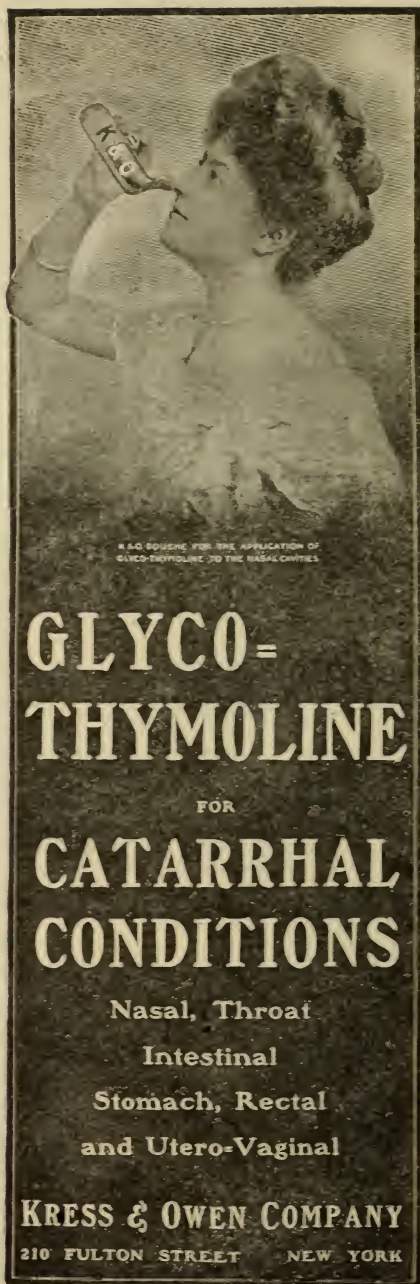
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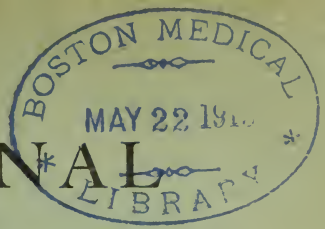
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JAN., 1913.

No. 6

EUGENICS.

An address delivered at the open meeting of the Portland Medical Club,
October 17, 1912.

DR. HENRY W. MILLER, SUPERINTENDENT MAINE INSANE HOSPITAL,
AUGUSTA, MAINE.

The science of eugenics, a branch of science originated by Mr. Francis Galton, who has devoted his life to a campaign in favor of it, is a science which has for its object not only the prevention of the birth of the unfit and undesirable, but the improvement of the race by furthering the productivity of the fit and by healthy rearing of children. It means briefly, proper breeding and rearing of human beings.

The laws of eugenics when finally promulgated will tend to the production of a more healthy race and will provide, not only for the raising of children from good stock, but will provide for the proper care of these children born from good stock. As Galton defines it, it is the science which deals with all the influences that improve the inborn qualities of a race. The principle involved in the science of eugenics is almost diametrically opposite to the laws of natural selection which depend on over-production and wholesale destruction with survival of the fittest.

There has existed for many years in this country a serious movement tending toward the prevention of disease, this age has been spoken of as the age of prevention of disease. The educational cam-

paign against the great white plague and contagious diseases is an indication of the tendency. There is shown a widening of the field of prophylaxis from personal physical hygiene to personal mental hygiene; there is a trend toward public or social hygiene and as a natural evolution of the tendency, social hygiene comes into the foreground,—the betterment of the human race by the greatest possible elimination of the bad, and the fostering and treasuring of the good for the supreme function of parenthood. To aim to produce the best type of men and women, to purify, better and advance the race is the object of eugenics or race culture.

A new science has sprung into existence as a result of the eugenic movement; namely, euthenics. This science has for its aim the betterment of the present generation by modification of its environment, whilst the science of eugenics is more strictly concerned with selection of heredity for future generations.

It is only within the last decade that public interest in this important question of the proper breeding of human beings has arisen, the result of the persistent agitation of Sir Francis Galton. It is a fact, which cannot be denied, that as a nation and as individuals we have given more serious study and investigation to the breeding of our animals than we have to the breeding and rearing of our future citizens. It is very gratifying to note the widespread interest in these questions. England now has a very thriving Eugenics Education Society. Germany is active in the work. Switzerland has many workers in the field. In this country, the American Breeders' Association has organized a committee on eugenics which is very active in its work in education, legislation and investigation.

A chair of eugenics has been established in the University of London, with Prof. Karl Pearson at its head.

The Eugenics Record office, in connection with the eugenics section of the American Breeders' Association is collecting valuable information, is elaborating systems for analyzing family pedigrees and is sending trained field workers throughout the country who are doing special research work in collecting pedigrees. In July, 1912, the First International Eugenics Congress was held in London, presided over by Major Leonard Darwin, a son of Charles Darwin.

As a practical people, we are asking ourselves, what is being done to limit the production of the imbeciles, insane, the criminals, inebriate, degenerate, and the other physically and mentally defective members of our community. We are spending millions every year for the care of our weak and defective dependents which will help only one generation. Is it not time to initiate some movement with the idea of

preventing the production of these defective classes and thus help further generations?

It is unfortunate that the meaning of the eugenic movement has become narrowed to a large extent in the popular mind. Eugenics means something more than performing an operation upon a certain class of our defectives with the object of preventing them from begetting their kind. The question of surgical intervention is only a minor phase of the eugenic problem.

Those measures which discourage parenthood of the least desirable have been classified as restrictive or negative eugenics, whilst the measures for encouraging parenthood of the most desirable have been classified as constructive or positive eugenics.

Restrictive eugenics has evolved two plans to prevent the undesirable from propagating his kind (a) Segregation; which consists in the maintenance of separate institutions for men and women during the reproductive period, where they should be confined and thus prevented from propagating their kind. A method theoretically ideal but practically impossible and (b) sterilization by operation. Thus asexualizing the individual and permitting him to have the greatest possible liberty but forever preventing him from propagating his kind. Sterilization has become almost exclusively confined to America. The practical results of this operative measure are as yet not determined. It has been said by its opponents that it is not effective because only those who are already segregated can be operated upon; and it has further resulted in the abuse of the operation by those who desire to be asexualized for other than eugenic purposes. There are also certain constitutional rights to be considered. We have now in at least ten States and in the Province of Ontario, Canada, laws inhibiting procreation in habitual criminals, vicious insane, feeble-minded, epileptic and other defectives. One was placed upon the statutes books in New York the present year. The New York law creates a Board to be known as the Board of Examiners of Feeble-minded, Criminal and other Defectives, to have supervision over the matter, the Board to consist of one surgeon, one neurologist, and one medical practitioner with ten years' experience.

In the other States, the practicability of the operation is decided upon by a Board of experts, following a thorough mental and physical examination. These laws give evidence that the citizens generally have been aroused to the danger which confront the communities in the unrestricted flow of degeneracy through the power possessed by the defective classes to propagate their kind. I cannot help but feel that the measure is too radical and is unwarranted in the light of our present knowledge.

We have yet much to do in creating public opinion relative to the many problems in connection with eugenics and social hygiene. We are beginning to understand the laws governing the hereditary transmission of normal and abnormal mental characteristics. The knowledge possessed by those versed in these problems should be available for the public good. Should it not be taught that the quality of the future race depends upon the quality of the children born and the influences to which they are exposed after birth (heredity and environment); that the quality of children depends upon the elements inherent in the germ cells of the parents and on the environment of those germ cells before their union and also after their fusion to form a new being; that a critical study of the relatives of a prospective parent will give valuable evidence regarding the nature of the elements inherent in his or her germ cells and likely to be transmitted; that poisons like alcohol and syphilis circulating in the blood of either parent may make the offspring the victim of a mental defect or a serious nervous disorder? If these facts were generally known and a healthy conscience created concerning the laws of social and mental hygiene, the present generation of young people would give more serious thought to marriage and the quality of the future generation would assuredly be improved.

Let us for a moment present statistics to show the proportion of the defective, dependent and delinquent classes. The census for Great Britain in 1901 showed 484,507 mental defectives of all kinds or 1 in 85 of the total population. There were 60,000 idiots, imbeciles and feeble-minded and of those, 19,000 were married and free to multiply and many of the unmarried were known to have been prolific, which is unfortunately a propensity of the feeble-minded class.

In the United States, it is estimated that in our 42 institutions for feeble-minded, 115 schools and homes for deaf and blind, 350 hospitals for the insane, 1,200 refuge homes, 1,300 prisons, 2,500 almshouses and 1,500 hospitals there are 300,000 insane and feeble-minded; 100,000 blind; 100,000 deaf and dumb; 100,000 prisoners, many thousands of criminals not in prisons; 23,000 juvenile delinquents in institutions, 100,000 paupers in almshouses and out of whom two-thirds have children and are also mentally and physically defective, and 2,000,000 annually cared for by hospitals, dispensaries and homes. These form 3 or 4 per cent of our population or one in thirty of our population is defective, dependent or delinquent. Do we require any racial regeneration? These figures might not indicate any startling national decadence but they surely show us that we ought to do something to stem the tide of the increase of this class.

I am not familiar with the statistics in this State, except for the

insane. It may surprise you to learn that the percentage increase of the certified insane in Maine during the past thirty years has amounted to 192.5 per cent, while the percentage increase of population during the same period is only 14.4%. We have under custodial care less than 300 feeble-minded at our institution in Pownal; while there are over 1,500 feeble-minded free to reproduce their kind.

HEREDITY.

The science of eugenics is built upon the fields of biology and sociology though its foundation is not as yet complete. One of the central themes of biology is heredity upon which the science of constructive eugenics rests. I have not the time to discuss the various theories which have been devised to explain the phenomena of heredity. I wish to mention briefly certain of the more important. Weismann's theory of the continuity of the germ plasma is very important. "According to this theory, there exists, in the reproductive organs of each individual, male and female, a germ plasma. This germ plasma is resident within the germ cells. These germ cells have no relation with the soma or body cells, the latter comprising practically all the other cells in the body. Activities or modifications of the body cells have no effect upon the germ cells, which can be affected only by such general conditions as toxæmias and intoxications, etc. It is the germ plasma which goes to form the new individual, in whom it again takes up its abode within the reproductive organ. Thus it passes through successive generations, ever unchanged except by such general conditions as were just mentioned."

Galton's law of ancestral inheritance maintains that there is an average degree of inheritance between parent and child, and this degree of resemblance is lessened in geometrical progression as we pass to grandparents and great-grandparents. In other words, of all the inheritance possessed by any individual, one-half is derived from his parents, one-fourth from his grandparents, one-eighth from his great-grandparents, one-sixteenth from all the rest combined. This law overlooks inheritance otherwise than direct parental transmission.

The laws governing the transmission of traits by heredity as established by Mendel as a result of his investigations of plant and animal life are now generally considered as applicable to man. According to the Mendelian laws, the total inheritance of an individual from his parents is divisible into unit characters, each of which is inherited independently of all the rest and may therefore be studied without reference to other characters. We think therefore, of an individual being as double in composition throughout. The inheritance of any character is believed to be dependent upon the presence in the germ

plasma of a unit of substance called a *determiner*. With reference to any given character or trait, the condition in an individual may be *dominant* or *recessive*. The character is dominant when, depending upon the presence of its determiner in the germ plasma, it is plainly manifest. It is recessive when, owing to the lack of the determiner in the germ plasma, it is not present in the individual. The male and female germ cells may make the same or different contributions as regards any of the ingredients. When the two cells yield the same contribution the organism which results is said to be *pure bred* for that ingredient; when the contribution from the two parent cells is dissimilar, the organism which results is said to be *cross bred*.

It is presumed that the full development and normal functioning of mental faculties are dependent on the presence of a special determiner in the germ plasm. An individual may inherit this determiner from both parents and we would have what is known as duplex inheritance or he might inherit the determiner from only one parent — simplex inheritance, or he may fail to inherit it from either parent, nullipex inheritance. (Charts illustrating the various theoretically possible matings based on the Mendelian laws were shown and also several charts of actual families, showing heredity in the feeble-minded.)

Imbecility is hereditary in about 65% of the cases and it is probably due to the absence of some certain definite factor in the parent germ cells. Many forms of insanity are hereditary though not always following Mendelian lines.

These studies on heredity are of the utmost importance for the understanding of normal and abnormal mental traits, and practical eugenics will profit by these facts of heredity.

Important as is the influence of heredity in the formation of character and mental traits, environment is almost equally important. We inherit certain potentialities, and modify certain of our inborn tendencies. It is possible in a limited sense to suppress certain inherited tendencies by environment and education, others may be encouraged. While the studies on heredity would seem to confirm the old doctrine of predestination, we are in reality learning that man to some extent may control his destiny.

Eugenics deals not only with the problems of heredity but with the problems of environment. Eugenics and euthenics are correlated in this wide movement for race improvement.

In considering the science of race culture, we cannot overlook the importance of insanity as a disease tending to racial deterioration and I wish to point out wherein we can make use of our knowledge of insanity in improving our stock.

There are in the insane hospitals of the United States about 300,000 insane at an annual public cost of maintenance of over thirty million dollars. It is estimated that the insane for 1909 meant a loss to the community of \$60,000,000 and that each insane person means a loss to the State of about \$400 per annum. The average cost of maintenance of an insane person in the public hospitals throughout the countries is approximately \$200 per annum and the average duration of life of patients in insane hospitals from twelve to fifteen years.

Insanity not only entails upon the community a heavy public burden but it entails very serious private burdens. It is claimed and justly, I believe, that insanity is one of the most potent factors of poverty and dependence. Aside from this somewhat material view of the effects of insanity, we must not overlook a more important result of this disease, namely, the distress and sorrow which fall upon the other members of the family. If anything can be done to prevent the spread of insanity and to check its development, why not do it? We who are in the work know certain facts about insanity and its causes, and it is time we took the public into our confidence and offered it the benefit of the results of our labor.

"The concealment of truth is the only indecorum known to science," wrote Westermarck. In no department of human affairs is this more true than in the veil of mystery that has been thrown around insanity and its correlated problems. We have no desire to conceal the truth either with regard to the facts about insanity or with regard to the care and treatment our insane patients receive in our public institutions.

What facts about insanity can we give at the present time to direct personal and public activity? We can tell what we know about the causes of insanity. We can state that we know that one-half of the cases of insanity are due to avoidable causes. If we impress upon the popular mind these exact avoidable causes, I am optimistic enough to believe that something will be done to prevent the operation of these causes. I am therefore going to tell you what we know about some of the causes of insanity. Not theories as to the probable causes but facts ascertained after very complete analytical studies of individual patients as a result of the newer scientific work now being carried on in the insane hospitals about which I am sorry I have not the time to speak.

Some of the different causes of insanity are immoral living, alcohol, physical disease, emotional stress, physical and mental exhaustion, domestic troubles and misunderstandings, faulty mental habits and inheritance.

You should know that one of our very common mental diseases,

general paralysis, paresis or softening of the brain is caused, in from 90% to 100% of the cases by syphilis. This disease, syphilis, caused the insanity in 8% of the cases admitted to the two hospitals in Maine during 1910 and in over 11% of the cases admitted to the Augusta Hospital in 1911. Throughout the whole country we find general paralysis includes 17% of the men admitted and 8% of the women. This type of insanity is an incurable disease; it results in rapid physical and mental deterioration and death in a few years. Syphilis is also accountable for a small percentage of other mental diseases as well as many purely physical disorders.

The facts about syphilis are generally known to the medical profession but to a very small extent to the non-medical world. Syphilis is usually the result of immoral habits. The danger of contracting a disease which may result in incurable insanity should be sufficient to prevent every man and boy from yielding to the temptation to go with immoral women, even if self respect, the desire for the good opinion of others, the influences of religious training and the attraction of home life are not sufficient to prevent this kind of wrong doing. This subject leads up to the question of sex instruction, a very important but neglected field and about which I have only to say that it is my firm conviction that instruction should be given the child in sexual problems but that it should be undertaken by the conscientious parent.

Alcohol is another avoidable cause of insanity. The close relation between alcohol and insanity has been recognized by alienists for years but the full realization of this relationship has only recently been appreciated. Statistics as to the number of cases of insanity in which alcohol is the direct cause varies in different localities. At the Manhattan State Hospital, N. Y., a metropolitan hospital, during a given time, Dr. Mabon, the Superintendent, writes that alcohol alone or in combination with other factors was the cause in 55% of the men and 25% of the women. On an average throughout the country, 30% of the men and 10% admitted to insane hospitals are suffering from conditions directly or indirectly due to alcohol.

In Massachusetts for 1910, taking the statistics for all the insane hospitals, we find alcohol intemperance as the sole cause in 16.50%, combined with other causes in 5.65%, making alcohol a causative factor in 22.15% of all admissions for that year. In this State where the manufacture and sale of alcohol beverages is prohibited, we find a relatively small percentage of insanities due to alcohol. At the Augusta Hospital, we find in 1910 in 2.91% of the cases admitted, alcohol was the sole cause and in 3.89% it was combined with other causes. So alcohol was a causative factor in 6.90% of cases admitted during the year.

At the Eastern Maine Insane Hospital in 1910, alcohol was the direct cause in 7.23% of the cases admitted that year and the indirect cause in 11.06% of the cases admitted; thus a causative factor in 18.29% of the cases admitted during the year.

At the Maine Insane Hospital in 1911, alcohol was the direct cause of the insanity in 4.42% of the patients admitted and in 8.49% of the cases admitted it was an indirect cause; a total of 12.91%.

These variations may not mean anything. I hope sometime to make an exhaustive study of the relation of alcohol to insanity in Maine, but the problem is complex and is one that requires most careful investigation. It is sufficient here to show the tremendous importance of alcohol in the production of insanity.

Alcoholic insanity may be caused by the regular use of alcohol even in quantities not sufficient to produce intoxication. The injurious effects of alcohol upon the higher nerve centres is well known. We know that even small quantities of alcohol lower the mental capacity and that alcohol does not assist us in either our mental or physical activities. In this age of keen competition every man needs the highest possible development of his mental capacities.

Some mental diseases are primarily caused by physical trouble which is not recognized. Hence the importance of seeking medical assistance for physical ailments. There is a close connection between the teeth, eyes, the ears, the throat and the internal organs with the nervous and mental reactions.

After tuberculosis, typhoid fever, other infectious diseases and kidney disease, a mental disease may follow, due often to the toxin developed in the system as a result of the disease but sometimes due to the mental discouragement.

Overwork is often spoken of as a cause of insanity. This never operates alone. It is only when overwork is associated with worry and loss of sleep that overwork becomes a menace to health. Henry Ward Beecher said "It is not work that kills men; it is worry." The control of infectious diseases, protection of food and water, healthful homes and factories, all these help to prevent mental as well as physical diseases.

Quite a large group of insanities is caused by purely mental factors, which are avoidable if the principles of mental hygiene are observed. "The healthy state of mind is one of satisfaction with life. This does not depend so much upon our surroundings, or how much money we have, or how many troubles come to us, as upon the way in which we train ourselves to deal with difficulties and troubles. Anyone who departs too far from this state of satisfaction must be regarded as tending towards an unhealthy condition. Of course not all

persons start with the same kind of mental make-up. Some owing to heredity, unusual experience, or bad training, have what is called a morbid disposition. But disposition is not something fixed, like the color of our eyes. It must be looked upon as made up of many tendencies which often can be changed or modified by training and proper mental habits. Health is a duty which the individual owes to himself, and to others. Mental health is as important as physical health. The average person little realizes the danger of brooding over slights, injuries, disappointments or misfortunes, or of lack of frankness, or an unnatural attitude toward his fellow men, shown by unusual sensitiveness or marked suspicion. Yet all these unwholesome and painful trains of thought may, if persisted in and unrelieved by healthy interests and activities, lead toward insanity. Wholesome work relieved by periods of rest and simple pleasures, and an interest in the affairs of others, are important preventures of unwholesome ways of thinking. We may not like even to admit the existence of these difficulties, but they are often the real cause of the brooding. To start doing something, to change the situation about which we fret, is the healthiest way to avoid aimless fretting. We should not hanker after the impossible, but learn to get satisfaction from what is at hand. We should not give ourselves up to day-dreaming, but try to do something, no matter how small it is. Delicacy or shame often prevents people from seeking advice, especially in regard to sexual problems, when such advice might be of the greatest service. Frankness should be encouraged by a sympathetic and helpful attitude toward those who are inclined to brood or seek solitary pursuits and pleasures to the exclusion of healthy social relations."

It is impossible in the time at my disposal to discuss the many side issues involved in this momentous problem. I have endeavored to give you a fragmentary outline of what the science of eugenics is and what it hopes to accomplish. Much remains to be done. We cannot hope to reach the eugenic idea very soon but we can disseminate what knowledge we have regarding mental hygiene, heredity and other problems in eugenics. We can all assist in creating new sentiments regarding marriage and parenthood. Organized effort is a distinguishing work of modern civilization and it is through organized effort that we are going to accomplish results in the field of eugenics.

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Ichthyol is helpful in the treatment of chronic non-suppurating paronychia. The underlying cause of the affection must be sought—syphilis, eczema, or favus of the nail, the use of caustic alkalies on the hand, etc.—*American Journal of Surgery*.

INSANITY AND HEREDITY.

Read before the Maine Medical Association Meeting in Portland, June, 1912.

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Insanity, today, forms a subject of exceeding interest because of the light thrown upon it by investigators of the problems of heredity. As an independent and distinct disease entity it is losing its identity. With our present understanding of the subject, the arbitrary lines formerly drawn between insanity, feeble-mindedness, and such mental abnormalities as criminality, etc., prove but insubstantial, artificial divisions founded mainly upon symptoms, — divisions serving to outline clinical groups, but not based upon underlying causes. Misleading divisions therefore they have proven, giving rise to errors in prognosis, management and treatment; for efficient management, adequate treatment and intelligent prognosis depend upon correct understanding of causes.

Until very recently, the medical man has regarded insanity as a distinctly medical condition, thus offering the prospect of improvement, recovery and cure under medical treatment. From the early days of the Worcester (Mass.) State Hospital when from 75% to 90% of cases measured the then claimed possibility of cures of recent cases, down to the present time when a recovery rate below 20% of admissions seems to demand an apologetic explanation in hospital reports, the promise of cure has been kept to the ear and as often broken to hope. This attitude, certainly not born of selfish motives, may and should merit praise when we reflect that it is characteristic of the earnest medical mind to hope even against hope so long as there remains a cause, a symptom, a single pathological feature not explained or understood; or it may revive the ancient accusation that the medical mind is peculiarly liable to the tendency to reason and conclude by precedent, and is therefore in a measure bounded and restrained by traditions. However this may be, there are signs that we are about to execute a right-about-face movement in our dealing with insanity. The studies of heredity and the startling deductions drawn from biometric and Mendelian investigations seem to prove to the satisfaction of all thinking persons that the insanities, (excepting the small part we may call acquired insanity,) feeble-mindedness, criminality, and like degenerative conditions are simply branches of one family tree — defect; and the questions of how best to deal with the insane, the feeble-minded and degenerate resolve themselves into one problem — the problem of the defective, or "the unfit."

Against the ponderous force of the evidence submitted by students of eugenics, ideas and opinions formerly held regarding curability of various forms of mental diseases, (admitted degenerative in origin and tendency) and racial improvement along the lines of training, education and all that is comprised by the term better environment, become feeble and unavailing. The conviction is forced upon us that inherent character and material civilization have little or no relation or connection; that environment is of much less importance than heredity in the mental, moral and ethical evolution of mankind; that treatment of defective conditions by medical means is in large measure useless, since it aims to restore what the sufferer never did, and never can possess.

The theories of eugenics rest solidly upon Weissman's law which represents that the germ cells which propagate the individual are independent of the body cells which make up the structure of the system; that education and other acquired characteristics have no effect upon the heritage of the germ cells which are distinct and apart and propagate only their own defects and virtues. Inheritance then depends upon certain determiners in the germ cells, and upon certain of these no amount of education, training, or favorable environment can have influence. The study of genealogy aims to test these theories and to trace out some of "the secrets of descent and destiny," and the results of the investigations pronounce in effect that our destiny is in our descent.

The laws of heredity as discovered by Mendel and elaborated by his followers show that you cannot by mixing hybrids produce a pure stock, that there will always be a majority of hybrids, a minority of pure stock, and another minority of bad and abnormal stock. If, for example, we mix the Anglo-Saxon with, let us say, the Spaniard, we never get a pure blended stock comprising the best qualities of either, but we get a hybrid stock, with a minority of individuals showing Anglo-Saxon traits in predominance, and another showing Latin traits predominant. Furthermore, if we bring into our nationality races or stocks with distinctly abnormal and anti-social traits, these can never be bred out of our nationality by inter-racial mingling."

"Coming to the physical and mental diseases, the same laws are supposed to apply. We cannot by the best possible methods of training and education make a poor stock with mental abnormalities a good one, and if we mix an abnormal stock with a good one such mixture will never entirely breed out the bad."

"Galton's law of ancestral inheritance is simply this: that of all the heritage which an individual possesses one-half, on the average, comes from his parents, one-quarter from his grand-parents, one-eighth

from his great-grandparents, and so on. Man has what Galton calls a 'Nature' or individual character and personality. This is made up of three things: First and most important is his heritage or his inherited characters. Second, certain changes or additions due to accidents of his conception, and growth before birth. Third, the acquired traits resulting from his education and environment. The part of man's 'Nature' belonging to heredity is the large and fundamental part especially as regards general characters and species."

(Dr. Chas. L. Dana. Problems of Heredity. Med. Record. Feb., 1910.)

A congenital predisposition to insanity, according to Morselli, exists in more than half or in about two-thirds of the insane; and Dr. White of the Government Hospital for the Insane, Washington, states that 90% is in all probability not far from the truth as regards the number of cases of insanity presenting hereditary predisposition. The peculiar condition founded upon a morbid heredity, and having the capability of transmitting defect to the descendants we call the neuropathic makeup. It shows itself chiefly under the manifestations of feeble-mindedness, epilepsy, grave hysterias, constitutional psychopathic states as mental instabilities, perversions, inversions and obsessions, manic-depressive insanities, paranoid and involuntional states, etc. The forms in which mental abnormalities of this type may appear are not independent hereditary entities, but are closely related one to the other and to criminality, so that what may appear as one form of mental abnormality in one generation may appear as a different morbid entity in the succeeding generation.

To the neuropathic makeup, we must attribute the alarming increase in population of our insane and defective; and, as we would expect, in the ranks of this class, we find the largest numbers of recurrent recoveries, so called, discharged as improved, much improved and capable of self-support — or re-admissions. The neuropathic makeup provides the soil and seed of degeneracy since it bears its taints and its defects within its germ cells; and the slight restrictions we have imposed upon individuals of this class, the special protection and fostering care extended by the State to the class, are largely responsible for the spread and increase of defect and degeneracy. Humanitarian and philanthropic agencies, too, have, through the laxity of the present system, wrought incalculable injury to the race in that they have made more easy and possible the tainting of good stock by mixture with bad.

Optimists warmly assure us that the race is improving. But let us examine our census reports and learn the lessons that cold figures convey. The general population of this State of New Hampshire in

1900 was 411,588; in 1910, 430,572, an increase of 18,989 or about $4\frac{1}{2}\%$. The number of registered insane in 1900 (exclusive of the number in prisons, jails, and private institutions) was 760; in 1910, 1,033; an increase of 273, or 35.1 per cent. Very likely people are more willing nowadays to commit their insane to State Hospitals; and accumulation of permanent residents of asylums, together with more thorough and accurate statistical data may in part account for this enormous increase. But even allowing for that, not even the most indifferent, nor the most infatuated believer in "cheerful yesterdays and confident tomorrows" can regard the situation with placid equanimity. And, mark you, these figures do not take into the account feeble-mindedness, and confirmed criminality, which have a common origin and a close relationship to the degenerative insanities.

Going outside of New Hampshire, we find similar conditions prevailing. From an excellent paper on the mentally defective by Dr. Drewry of Petersburg, Va., I quote the following facts and figures. From 1904 to 1910, the population of the United States increased 11 per cent, while the number of insane persons was augmented during the same period by 25 per cent. During the past quarter of a century, there has been a rapid increase in the hospital accommodations for the insane, still the increase in such accommodations has not kept pace with the increase in the insane population. From 1900 to 1910, the population of Rhode Island gained 26.6 per cent, while for the same period the number of patients in the State Hospital gained 53.1 per cent. In New York, Dr. A. W. Ferris, Ex-President of the New York Commission in Lunacy, reports that the increase in insanity since 1890 has been 104 per cent, while for the same period the increase in the general population has been 47.6 per cent. In Alabama, the increase of admissions into hospitals for the insane during the past ten years has been 45 per cent, while the population increased about 16 per cent. In Virginia, the general population was augmented 11.2 per cent from 1900 to 1910, while the registered insane advanced 50 per cent.

Dr. Drewry estimates there were six times as many individuals sent to the State Hospitals in Virginia for the first time between 1900 and 1910 as between 1870 and 1880, therefore, he says, in a single generation the number of insane persons sent to the hospitals had increased about 500 per cent. I am not prepared to say what proportion of the total insane population of the United States consists of persons re-admitted to State Hospitals, but in a general way, it is correct to state that from 20 per cent to 25 per cent of admissions of all State Hospitals are cases of re-admission.

Turning again to New Hampshire, we find that the total number of insane cases admitted to the State Hospital from October 1, 1900 to

September 1, 1910, was 2,649; 618 or 23.3% of the total admissions were cases of re-admission. Herein we are tempted to think we have one possible explanation of the increasing growth of degeneracy, from which valuable suggestions for future guidance may be drawn. Subtracting the number of re-admissions from the yearly admissions to State Hospitals would substantially lower the alarming rate of increase of insanity. Were it possible to deduct from the tables of statistics the number of insane descendants of these same re-admitted persons, the reduction would be so marked as, I believe, to show an actual decrease in insanity commensurate with our better habits of living and improved environment.

The total discharges of insane cases from the New Hampshire State Hospital during the period 1900 to 1910 were 1,330, of which "recoveries" numbered 606 cases. Of the "recoveries" 210 cases or 33.1 per cent of the total were cases of recoveries from other than first attacks.

During the same period, the number of cases discharged "not recovered" was 723, or 54.3% of the total discharges. Of these, 437 or 32.8% of the total discharges were recorded as "improved" and "much improved," and 286 or 21.5% of the total discharges were dismissed to the community "not improved." And it is more than probable, aye, almost certain, that the majority of such non-recovery discharges were of neuropathic, or defect-transmitting persons. It is fair to assume that the repeated recoveries occurred in persons in the early and middle periods of life — that is, in the sexually productive periods of life. The assumption is justified by common experience and by the fact that 109 cases or practically 18% of the total recoveries were cases of repeated recoveries ranging from the third to the fourteenth recovery. And recurrency in itself indicates a neuropathic or defect-transmitting taint.

As to the ages of those discharged "not recovered" we have no data from which to draw an accurate estimate. Excluding cases of gross brain lesions and other forms of acquired brain diseases — that is, not essentially hereditary in predisposition — the greater number of discharges "not recovered" would probably be cases of persons in the reproductive period of sexual life.

Of the cases of insanity from gross brain lesions the percentage of discharges, "recovered," "improved" and "much improved," must be negligible. They constitute a large proportion of the life residents of hospitals for the insane whose chief effect upon the movement of insane population consists in swelling the admission and death rates.

As distinguished from the essentially hereditary and defect-transmitting insanities, the other acquired mental disorders — infection

and exhausting psychoses, the toxic as alcoholic and drug psychoses, the psychoses of auto-intoxication, uremic, polyneuritic, etc., — constitute with the exception of alcoholic cases, but a small proportion of the total admissions. Discharges of alcoholics have been very generally rated as recoveries, those not thus discharged becoming largely a part of the life-residents of the hospital. Basing our opinion upon the nature of the disease, the probable termination of the other acquired psychoses referred to above would most likely be recovery, or fourth of the total number discharged "not recovered" would more than cover the part of that total formed by cases of acquired mental disorders.

Thus, we may say, about three-fourths of the total discharges "not recovered" were cases of mental diseases generally considered as hereditary and defect-transmitting, and of these cases it is quite safe to say the majority were persons in the reproductive stage of life.

These figures should not excite surprise. Under our own present system the patient who has improved to the extent that he presents the appearance of normality, may practically compel the hospital authorities to discharge him. The guardians or friends who pay patients' expenses, may remove them from the hospital whatever their condition. County Commissioners, city and town officials hold the same authority in the case of county or town patients supported by the State, and in more than one instance this has been exercised as a result of the importunities of patients' friends. Moreover the discharging of patients is forced upon the hospital in order to accommodate the new cases each year. There never has been a time when our State hospitals have not been over-crowded, and there never will be until the growth of degeneracy is checked.

A consideration of these estimates enables us to imagine the vast possibilities of propagation of vitiated stock by that portion of our nationality which at one or more times formed part of the population of hospitals for the insane. Hospital statistics are of use in enabling us to form opinions of possibilities; they do not enable us to arrive at definite figures of fact in regard to this point. This is not to be wondered at considering that investigations of this kind require a very thorough and extensive field-work service involving great labor and expense. But enough has been done by investigators to show the terrible price society pays for its indifference to the blight of degeneracy. The genealogy of the notorious "Jukes" family, prepared by Richard Dugdale, shows from 1720 to 1874, some one thousand two hundred defective descendants from one "Max," a shiftless vagabond, drunkard and defective. 310 were in poorhouses; 300 died in childhood; 440 suffered from vicious diseases; 400 were early vic-

tims of their own excesses; 50 were notorious prostitutes; 7 were murderers; 60 were thieves who spent an average of twelve years in prison; 130 were convicted more or less often of crimes; and of the total descendants very few seemed to be decent. This single family cost the State of New York, \$1,250,000, or one thousand dollars for each of its degenerate members up to 1877, and as Davenport states in his studies of heredity, their protoplasm has been multiplied and dispersed during the subsequent 34 years, and is still marching on.

A professor in Berne University has traced the history of a family which gives striking testimony to the force of heredity. In the end of the 18th century, a woman died who for forty years had been "a thief, a tramp, a drunkard." From this woman there rose 834 descendants, 707 of whom have been traced from youth to old age. Of these, 106 were born out of wedlock; 142 were beggars and 64 more lived on charity. Among the women, 181 lived loose lives, and in the family have been 76 convicts and 7 murderers. He estimates that in 75 years this family has cost the German authorities in alms houses, law courts, prisons and other institutions about a million and a quarter dollars. Dr. Goddard of the Vineland (New Jersey) Training School has traced out similar conditions in degenerate families in America. From the literature of defect instances like these may be multiplied. The New Hampshire State Hospital is now conducting an excellent field-work service, the results of which promise to be fully as enlightening and interesting as the findings just quoted.

From our estimate of the number of possible defect-transmitting cases discharged from State Hospitals in the reproductive period of life, and bearing in mind the well known fact that of all classes the degenerate and defect-transmitting are the least likely to govern their desires and passions by altruistic considerations of social and racial welfare, the claim may be advanced with some show of justification that under the existing system remedial and corrective agencies have to a great degree failed in their purpose. Viewing the field of insanity and defect in the light of the laws of heredity the present day conditions may be, not inaptly, described in the words of the Shakespearian simile on Glory — being like unto a circle in the water which never ceases to enlarge itself.

Our estimates indicate that the insanity or defect-furnishing part of our population must be well-limited to certain strains; that the increase of insane population may be largely accounted for by the fact that civilization with its humanitarian and philanthropic agencies has practically reversed the natural law of "the survival of the fittest," so that to-day the "unfit" stands an equal if not a better chance of surviving; that remedial and corrective agencies under existing

conditions are indirectly instrumental in increasing the numbers of the "unfit," inasmuch as they serve to ameliorate, not cure, the manifestations of morbid heredity and degeneracy, — and most important consideration of all, improve the physical fitness of the "unfit," thereby enabling them the better to exercise the rights and privileges of normal individuals, and enhancing and making more possible the growth and multiplication of poor and degenerate stock.

This condition of affairs leads Dr. Havelock, the great English scientist, to observe that "the social reform that has been concerned with the improvement of the conditions of life has had the altogether unexpected and undesired result of increasing the burden it was intended to remove. Not only are we making the way smooth for the fit; in even greater measure we are making it smooth for the 'unfit.' We have been helping the 'unfit' to compete with the fit. We have been encouraging them to propagate their kind — to pass on their unfitness to future generations. We have been expending enormous enthusiasm, labor and money in improving the conditions of life with the notion in our heads that we should thereby be improving life itself, and after seventy years, we find no convincing proof that the quality of our people is one whit better than it was when, for a large part, they lived in filth, were ravaged by disease, bred at random, soaked themselves in alcohol, and took no thought of the morrow. Our boasted social reform, we are thus tempted to think, has been a matter of bricks and mortar — a piling up of hospitals, asylums, prisons and work-houses — while our comparatively sober habits may be merely a sign of the quietly valetudinarian way of life imposed on a race which no longer possesses the stamina to withstand excess."

The adequacy and efficiency of the existing system of dealing with the problem of the "unfit" is thus fairly open to question. Despite all that has been done in the way of curative, preventive, and corrective measures the evil is spreading wider and eating its way deeper into our nationality. The experience of the past affords no hope of improvement of conditions in the future, if we go on as we are going. The burden of support and maintenance of remedial and corrective agencies is becoming one of the most serious economic problems of the age. The heritage of evil which, by our present system, we transmit to posterity is appalling to contemplate, leaving out of consideration the economic question, the ethnical aspect of the problem — this "watering the blood of the race" as Dr. Eliot terms it, this crime against the race — forms a subject worthy of the darkest chapter in the history of mankind.

What can be done, then, to stop this fast-spreading and far-reaching evil? Temporary detention in hospitals, followed by im-

provement and discharge but make a bad matter worse. "Cures" and "improvements" prove uncertain and fallacious. We are forced to agree with Dr. Rosanoff of Kings Park Hospital, that "the prognosis of insanity" (and we may add of all defect) "of whatever nature or origin, is as a rule, gloomy. Very few cases, indeed, recover permanently. Further it must be pointed out that treatment may be palliative but does not materially affect the prognosis, and that in a given case the course and termination will depend simply upon the nature of the disorder and may be predicted without reference to the management of the case." In State of New Hampshire, while statistics show 19.7% recoveries of the total insane population of our State Hospital during the ten years under review (606 recoveries out of a total insane population of 3,074) recoveries from alcoholism formed 19.1% of the total recoveries; while 33.1% of the total were "repeaters" or temporary recoveries. Were all the cases of recovery from acquired forms of insanity deducted from the total, the percentage of recoveries would be insignificant. The purely "hospital" plan of dealing with the degenerative insane and defective, implying possibility of cure and restoration, does not therefore seem to offer a solution of the problem. For it is expensive, it is simply a palliative measure, and it certainly tends to increase the very burden it is intended to remove.

The question is a medical one, of course, in certain respects; but even more forcefully it is a sociologic and biologic question. Medical care of the insane is surely necessary, perhaps more necessary than for any other class. But hospitals and purely medical treatment alone will never solve our problems. The question has biologic, sociologic and economic aspects which demand a re-organization of our forces, whereby prevention and some relief from the burdens and handicaps of supporting an ever-increasing army of indigents may be obtained. The resources of medicine have been exhausted in the singlehanded struggle to cure and improve, where in reality — following physical improvement by medical treatment — the teacher who might discover and train such mental faculties as the sufferer possessed to the end of making him partially or wholly self-supporting, and the biologist and sociologist who might formulate and apply preventive measures, constitute the chief forces promising hope for the future. This is not meant to convey the idea that medical supervision of the insane and defective should be abolished, for nothing in my opinion could be more undesirable than that; but rather to enforce the lesson of experience, that "chasing the rainbow" of curability should be subordinated to, or at least associated with effective measures for prevention and safeguarding the future of the race. Nor is it designed to convey an impression that State care of the defective is unnecessary. Not until

the State assumes and exercises full control over the lives and destinies of its "unfit" will the burden ever grow lighter.

Segregation, or permanent detention, and unsexing or rendering impossible the multiplication of the "unfit" by way of interfering with the processes of reproduction, seem to be the only ways of making prevention practical and effective. Segregation of the defect-transmitting throughout the reproductive period may be expensive, but properly enforced, says Dr. Davenport of the Carnegie Institute, "there is reason to anticipate such a reduction in defectiveness in fifteen or twenty years as to relieve the State of the burden of further increasing its institutions, and in thirty years, most of its properties especially acquired to accommodate all the seriously defective could be sold." But such segregation should mean something more than mere custodial care. Mere custodial care is wasteful and extravagant. Segregation should include industrial training and re-education in habits of useful occupation in order to make as much as possible of the mental faculties remaining to the sufferers, and to render them entirely or partially self-supporting. And here hospitals for the insane may study to advantage the methods pursued in schools for the feeble-minded where re-education and industrial training are the main features of management. Dr. E. R. Johnston of the Vineland Training School makes the statement that 30 to 50% of the feeble-minded can be made self-supporting after ten years' training. Finally as much it would seem might be accomplished with the degenerate insane, who in most cases have already formed to a greater or lesser degree, habits of industry and occupation prior to commitment. The experience of Massachusetts with its successful colonies for the chronic insane at Gardner, and other places, not alone points out a means of some relief from the burden of support of the defective, but shows also the immense value of occupation and industrial education in the management and treatment of the insane. Abandoned farms were purchased by the State; workshops, offices and hospital wards erected; farm buildings, already standing, repaired and occupied, and here at a cost of much less than that of hospital accommodations and under the most ideal conditions — country life, pure air, outdoor occupation as well as indoor work — a great deal is being done for the physical as well as mental improvement of that class called chronics, generally regarded as the most hopeless in our hospitals. Under this method, the general health of patients improves, the cost of maintenance is greatly reduced, the returns from patient labor contributing largely to their support. Segregation of those with protoplasmic defect, in farm and working colonies, training in industrial occupation, and this as a large and important adjunct to the hospital, would seem to be a rational, economical way of coping

with the issue, if we are to take effective measures to weed out degeneracy.

Asexualization is already enforced in some States. Under certain precautions, sterilization is legalized in six States of the Union—Indiana, Connecticut, California, New Jersey, Ohio and Utah. In most of these States these laws apply only to confirmed criminals, but there is a growing inclination to extend their provisions to degenerates generally. Before the passage of the law authorizing Vasectomy in Indiana, many criminals and defectives had submitted to the operation, voluntarily sacrificing their procreative power. Vasectomy for men and salpingectomy for women are probably the best, simplest and most desirable surgical means of preventing procreation. Vasectomy does not deprive a man of sexual desire, or pleasure, nor of sexual secretion, but it does deprive him of means of impregnation. The functions may be restored if restoration be considered advisable. Dr. Sharpe of Indiana, who has performed the operations upon over five hundred men, states that mental stamina is increased after the operation, and that physical as well as mental benefits are conferred.

Some of the advocates of vasectomy and salpingectomy do not hesitate to claim that in four generations they would be the means of wiping out nine-tenths of the crime, insanity and degeneracy in our land.

Whatever the means employed to enforce it, prevention seems to be the essential in any scheme for lessening the numbers of the degenerate. Whatever the sentimental objections that may arise regarding the rights of the individual, the situation resolves itself into sentimentalism and the generation of the "unfit" on the one side, and prevention and a re-generation of the race on the other. The welfare of the nation depends upon whether or no rational action be taken in this matter and rational action must be in accordance with the laws of science. At the outset it may not be possible to apply preventive measures to all the known classes of the defective and defect-transmitting. But no one can doubt the advantages to our nationality were the feeble-minded, the epileptic, the degenerate criminal and certain degenerative forms of insanity commonly called "functional," such as recurrent insanitis, dementia precox, psychopathic states, etc., prevented from propagating their defective protoplasm. "Concerning heredity in the functional forms of insanity," observes Dr. Davenport, "there is no doubt. But the mental defect that is inherited is not always of the same type. In the same family may be found cases of manic-depressive insanity, senile dementia, alcoholism and feeble-mindedness. It would seem to be the neuropathic taint that is inherited. This is the conclusion to which Cannon and Rosanoff have come in their study based

on house to house investigations of the families of patients at a State Hospital. They omit from consideration the "organic" class of cases as probably purely exogenous in origin. Aside from these, they find that when both parents have any form of insanity all of their children will "go insane." If one parent is insane and the other normal but of insane stock, half of the children tend to become insane; when both parents, though normal, belong to an insane stock, about one-fourth of the children become insane. The typical laws of heredity are followed here." (Davenport. Heredity in relation to Eugenics.)

Before the first step toward effective prevention can be taken the public mind must be instructed in the consequences and dangers of "racial taint." Heretofore the effect had been to minimize the danger, to remove the "stigma" as it was called from insanity; indeed this was one of the arguments advanced in behalf of the hospital plan of treatment of the insane. But adequate and intelligent legislation upon this subject depends upon an intelligent understanding of conditions, and a sense of public responsibility founded upon correct knowledge. When this has been attained the "stigma" falls not upon the sufferer, the unfortunate victim of circumstances over which he has no control, but upon the social system which makes such misfortunes possible; and this is just as certain as it is today that the existence of a preventable disease like typhoid is a reproach and a discreditable reflection not upon the sufferer but upon the sanitary intelligence of the community.

Since this paper was written, a leading alienist in a neighboring State has contributed an article to a metropolitan paper criticizing methods of estimating the increase of insanity based upon comparisons of the population of registered insane to the general population. The proper method according to this authority is to estimate the number of first admissions or "occurring" cases, and compare with the general population. Following this suggestion it is found that the number of first admissions to the New Hampshire State Hospital, or "occurring" cases show an increase out of all proportion to the general population. Here is the result:

Number of first admissions in the 10 years ending March 31, 1890 = 1,108; September 30, 1900 = 1,274; September 30, 1910 = 2,061.

Increase of first admissions, decade ending 1900 = 166, or 14.9%; 1910 = 787, or 61.7%.

General population, 1900 = 411,588; 1890 = 376,530; Increase = 35,058 or 9.3%.

General population, 1910 = 430,572; 1900 = 411,588; increase = 18,974, or 4.6%.

The difference in number of first admission in these decades may partly be explained by the fact that a number of "occurring" cases of insanity were in the earlier decade sent to county farms, now all such are sent to the State Hospital. Neither this factor, nor the possible growth of an increasing disposition on the part of the public to commit its insane to the State Hospital can account satisfactorily for such an enormous disproportion of "occurring" cases of insanity as compared to the general population. It seems there must be an actual disproportionate increase. The figures 14.9% and 61.7% increase of "occurring" cases to 9.3% and 4.6% increase of general population tell a story that carries its own moral. Surely the situation is a serious one, calling for active preventive measures.

The latest and most reliable statistical data furnish irrefutable proof of the fact that insanity is on the increase and shows also the rate of increasing. An enumeration has been made of all mental defectives (idiots and imbecile as well as insane) existing in the Canton of Bern, Switzerland, on May 1, 1902, in their homes as well as in the various asylums. A comparison of these statistics with similar statistics obtained under identical conditions in 1871, gives the following results:

Total population, Canton of Bern, in 1871 = 501,501; in 1902 = 589,433.

Number of mental defectives in 1871 = 2,804; in 1902 = 5,029. i. e., in 30 years, the total population of the Canton of Bern increased by 17 per cent, while the number of mental defectives increased by 79.4 per cent. It is hardly necessary to paint out the gravity of such a showing."

(Dr. Fursac, Handbook of Psychiatry, third edition.)

It may be said without fear of contradiction that the affairs of the insane in New Hampshire are as ably and wisely administered as they are in any State or county. In every State where preventive measures are not enforced, the same conditions as in New Hampshire will be found to exist. Admitting the force of heredity in degenerate stock a disproportionate increase of defectiveness necessarily follows when defect-transmitting persons are discharged in the full possession of their reproductive powers, whether such discharge be rated as "recoveries" or "improvements." It must be borne in mind that preventive measures can be applied only after the subject is committed to an institution, and expert diagnosis made. Commitment must precede preventive procedures. A thorough field-work investigation will show, as it has in New Hampshire, and in the investigation of families of patients in a State Hospital by Cannon and Rosanoff of King's Park Hospital, the actual findings as respects the offspring of the

degenerate insane to approximate very closely to theoretical expectation according to Mendel's law; and that the transmission of defect to the offspring seems to be in no wise modified by the accident of "recovery" or "improvement" in the case of the progenitor whose attack of insanity is an expression of a defective make-up.

THE MEDICO-SURGICAL TRANSITION PERIOD.

BY H. F. TWITCHELL, M. D., OF PORTLAND.

Read before the August Meeting of the Washington County Medical Society.

There are certain diseases like the essential fevers which are always medical, others like tumors which are always surgical; another class, like pleurisy and tuberculosis which are sometimes strictly medical and at other times strictly surgical; and then there are diseases in a debatable category, like exophthalmic goitre, which some physicians consider to be always medical and others always surgical, and still others sometimes medical and sometimes surgical. It is fair to assume that most diseases have both medical and surgical aspects; and the best end-results in their treatment will be obtained if the physician and surgeon can agree upon the transition period from one phase of the disease to the other. It is the purpose of this paper to help indicate, in certain diseases, this transition period. Naturally the physician is loath to relinquish and the surgeon is eager to assume control of such cases; and therefore it is an experienced, fearless, unselfish physician that can act without prejudice, thereby giving his patient the advantage of the best medical treatment. It will be apparent, we hope, that the paper is not simply a plea for the transference of patients from the physician to the surgeon, but an argument for such combined skill that the sufferer shall receive the best services.

It is a frequent experience of the surgeon to be called hours and even days too late for his best service. The great responsibility usually rests with the physician of recognizing the transition period—of determining when surgical aid shall be invoked. Therefore the physician requires an education broader, deeper and more general than the surgeon in his more restricted field.

There are many chronic invalids in every community. They are the support and sycophants of the charlatan, and a reproach to the regular profession.

A large per cent of these could be cured, or, I better say their invalidism could be prevented by a transference at the proper time

from medical to surgical hands. As an illustration of what I mean, let me outline two classes of these sufferers: patients with chronic pelvic disease, and others who suffer from so-called bilious dyspepsia.

The first class have been treated irregularly for years with tampons, douches and electricity, and the second class both with scientific prescriptions and all the nostrums of the drug shops. Such measures can give only the most transient relief and cannot possibly remove the pathological condition. Most of the first classes have borne children and the pathology is sub-involution with all its attendant evils. The others in this class have never been pregnant but from some cause, obscure or not, have developed an hypertrophy of the womb or follicular degeneration of the ovaries. It is the constant irritation in these cases that produce invalidism, and if allowed to continue for years it is almost impossible to restore health. The prominent symptoms are sometimes menorrhagia, sometimes backache or pelvic weight and tension, or local pain, or nervousness, but usually part or all of these symptoms combined.

The menorrhagia is due to a myopathic condition whereby the muscular fibre of the uterus is supplanted by fibrous tissue. Curetting gives but a transient if any relief to the bleeding. Hystereotomy is usually the only operation to be considered.

In the other class of cases—the dyspeptics—the cause of the trouble is in the gall bladder or duodenum or stomach. Here is a class of cases in which physicians often content themselves and their patients with a diagnosis of “indigestion” which may be but a symptom of some grave surgical disease. In disease of the stomach or duodenum, pain or vomiting or both are the cardinal symptoms, but as those symptoms may attend functional disturbances also, it requires discrimination to determine when the transition period between medical and surgical treatment has arrived. Functional disturbances quickly yield to treatment, do not recur regularly, and are without sequælae. If the pain and vomiting are not relieved by diet and medication within two or three weeks, the case probably has some organic basis. Vomiting blood or blood in the stools, pain always referred to the same spot and occurring at a definite time after ingestion of food, progressive loss of flesh, are sure symptoms of organic disease indicating that the medico-surgical transition period is already past, while the development of cachecia and tumor before surgery is invoked is a reproach to the profession. When the diagnosis is absolutely certain the prognosis is equally certain. Speedy death is inevitable. The rarity of gastroenterostomies and partial gastrectomies in our vicinity is a significant commentary upon the tardy diagnosis of our physicians. Of all the exploratory incisions I have made, about ten per cent only

have been early enough to accomplish any good. I have recently seen two cases where only a palliative gastroenterostomy could be made, and yet these patients had suffered from symptoms that should have brought them to the surgeon months earlier.

Gall bladder disease is frequently dallied with by physicians long after it has ceased to be medical. They satisfy themselves with the treatment of "biliousness." If a patient has repeated attacks of hepatic colic, passes gall-stones, or has persistent jaundice, the case is of course clear. But cholecystitis with or without gall-stones does not always produce these definite symptoms. The patient may have simply recurrent attacks of flatulance with indefinite pain radiating not downwards but through to the back or into the hypochondriac regions. If there is also occasional slight jaundice and tenderness over the liver, the case is quite clear.

Acute cholecystitis is often mistaken for cholangitis or typhoid fever. Acute essential cholangitis is but a transient disease not attended by pain or high fever. If jaundice does not promptly subside, if convalescence is not established inside of four weeks, there is mechanical obstruction to the ducts calling for surgical interference.

Septic cholecystitis often gives symptoms suggesting typhoid fever; but the fact that the symptoms so far as their typhoid character are concerned are abortive, and the finding of tenderness and rigidity over the gall-bladder should be sufficient to determine the diagnosis. A degree of jaundice is a late symptom indicating extension to the bile ducts. Such cases demand prompt surgical interference.

A case illustrative of the first class I operated on some time ago. A woman sixty years old who had been treated for biliousness by her physician for fifteen years. A gall-bladder tumor had gradually developed as large as a grape-fruit and literally as hard as a rock. I removed a hundred stones as large as chestnuts; but long continued irritation had produced cancer which caused death a few months after the operation.

A case that I believe to have been a type of the second class I saw in consultation in a neighboring State. A man forty-eight years old, weighing one hundred and ninety pounds; good habits; family history negative. After a few days of malaise and fatigue, he consulted a physician who found a temperature of 102.5; the next day it was 103.5, and the next day 104.5; some diarrhoea and a little nose-bleed. At the end of a week, his temperature was nearly normal; he was constipated, slightly jaundiced, mind dull. At this time he was moved to a hospital and I saw him one week later. His tem-

perature for a week had been recorded as sub-normal with a pulse of 80. The day before I was called his pulse ran up to 120 and remained there. I found rectal temperature of 99.4. He was deeply jaundiced. He was easily roused but quickly lapsed into condition of stupor. No rose spots, not much meteorism, but some tenderness and resistance over gall-bladder. Wiedal had been ordered but no blood count made. His family physician and the whole medical and surgical staff of the hospital had seen him the day before and agreed that he had typhoid fever with intercurrent jaundice, notwithstanding he had not carried to a typical conclusion a single symptom or group of symptoms of that fever. Laboratory tests should have been earlier made. The Wiedal report negative was received after his death. Blood count would doubtless have showed high leucocytosis as he was very septic. He was buried without operation or autopsy. Personally, I think it was a case of septic cholecystitis. The inconclusiveness, the abortive character of the typhoid symptoms; the jaundice with tenderness and resistance over the gall-bladder, a negative Wiedal and positive leucocyte should have differentiated the diagnosis. The transition period was when the typhoid symptoms aborted and jaundice began to appear.

Experience has taught me that quite a percentage of pneumonias terminate in pleuritic effusion. The pneumonic condition precedes and overshadows the pleuritic, therefore we diagnose pneumonia and consider the diagnosis settled for all time. The human tendency to be tenacious of first impressions is to be deprecated in the diagnostician. I have seen patients so far convalescent as I supposed from pneumonia as to discharge them only to be recalled a few days later for a pleuritic effusion. It is a matter of personal good fortune when the recall don't go to another physician. Convalescence is established in uncomplicated pneumonia by the end of two weeks. A relapse of fever with increase of respiration means a new pneumonic focus or involvement of the pleura. Therefore if in a given case the normal chest signs do not begin to re-appear at the end of two weeks, or if after a few days of improvement there is a relapse, some complication has arisen. You have probably reached the transition period. Beware of the terms "chronic pneumonia" and "delayed resolution;" they are the sign boards of complications — usually effusion, probably pus. A typical case of empyema in an adult is the following: A farmer, forty years old, always well, was attacked with grippe. I was called in consultation after he had been sick three weeks. You could look in at the window and make a diagnosis by his attitude, labored breathing, anxious expression, sweating and pallor, all indicating a late stage of septic empyema; and yet two days before one of the best physicians

in our State had diagnosed effusion but advised waiting for subsidence of the fever before operating. Gentlemen, fever, when caused by a surgical disease, is never a contraindication for operating.

A case in a boy three years old illustrates a frequent medico-surgical sequence. The third day following an attack of influenza rales appeared in the left chest with a little pain. Two days later, the fever and physical signs had nearly disappeared, his appetite was better and he called for his playthings. I discharged him, only to be called again two days later, when I found return of fever and increased respiration with dullness at base of lung. The transition period had been reached. He was no longer medical. He was cured by drainage.

Tumors of the breast impose upon the physician grave responsibility. The lives of these sufferers are in the hands of the physician whom they first consult, provided they accept his advice. The force of this statement will be apparent when we remember that ninety per cent of all breast tumors are malignant. Only small, circumscribed, movable, painless tumors in women under thirty should be temporized with. All tumors attended by pain and all presenting any of the malignant characteristics, all occurring in women past thirty years of age should be removed. The transition period is between these two groups.

OBSTRUCTION OF THE BOWELS.

These are cases that must be promptly diagnosed if they are to be saved.

The initial symptoms of pain and vomiting may mean indigestion simply; but, if so, these symptoms will cease when the stomach has been emptied. It is a wise measure in these cases to wash out the stomach; and if the symptoms persist there is probably organic obstruction. Of course if flatus refuses to pass down, the abdomen distends, the pulse runs up, vomitus becomes fecal, and the patient toxic, the case is clear. It is probably too late for a successful operation.

I have operated upon two good illustrative cases recently. A male patient thirty years old suffered from a severe bronchitis for a week. Then persistent vomiting began with slight abdominal pains. The stomach was washed but vomiting persisted and the abdomen began to swell. Here was the transition period; but the patient went nearly two days longer with fecal vomiting and increasing pulse before surgical aid was sought. A diagnosis of internal hernia, probably produced by coughing, was made. A strangulated hernia of the ilium through a ring formed by an adherent appendix was found. How

trivial the lesion! How opportune the intervention of the surgeon! The patient was saved by the narrowest possible margin.

I operated not long ago on a case of strangulated inguinal hernia that had existed with fecal vomiting nearly forty-eight hours. He was too toxic to recover.

ECTOPIC PREGNANCY.

These are cases that are sometimes diagnosticated at the autopsy. They frequently go on to a depleting hemorrhage and impending death before a diagnosis is made; and yet most of these patients consult their physician for the initial symptoms of colicky pains, menorrhagia, stomach symptoms or supposed miscarriage before alarming symptoms appear. Such a group of symptoms should be immediately so carefully investigated that the physician can satisfy himself on this point. Ectopic pregnancy is presumptive if searching inquiry elicits the fact that menses has been a little irregular as to time or quantity, that slight flow has persisted, that there have been colicky pains in the pelvis and, if associated with these symptoms, there have been significant stomach and breast signs, or if some undue tenderness or tumefaction can be found in the pelvis. Colicky pains, or suspicion of tumor in the pelvis outside the uterus, in conjunction with the other symptoms indicate the transition period.

I have twice diagnosed and operated such cases within three weeks of conception and before rupture had taken place. It is no unusual thing for surgeons to operate upon these cases when in extremis, although suspicious symptoms have existed for some time. And many of us can cite cases where death has been precipitated by a curetment for a supposed incomplete miscarriage, no provision having been made for quickly opening the abdomen.

Enlargement of the prostate is a troublesome disease for any but the specialist to treat and yet there are a great number of these sufferers dragging out a miserable existence under the inefficient care of their family physicians. Most of these patients first consult the physician for retention or infected bladder. When medical treatment does not cure the infection or the tendency to residual urine, the transition period has been reached and they should be turned over to the surgeon.

APPENDICITIS.

The most often medically abused of all surgical diseases. It seems incredible that there are still physicians who will dare to claim that they have never had any deaths from appendicitis, having always cured these cases by medical means alone. I saw such a man last month. He had been practicing twenty-four years. He had a girl patient who

came near spoiling his record, although, had she died unoperated, I doubt if he would have known what she died from. She had been suffering from appendicitis for a week. A surgeon should have been called as soon as pain or tenderness attended by fever, located itself over the appendix. In fact, it were better in this disease to place the transition period where the diagnosis is first made. The third day the girl was better. The fourth day not so well. A surgeon certainly should have been called then, for a relapsing appendicitis means either operative interference or death. But not for two days later, until the child was entering the last stages of sepsis, and death was imminent, would this physician consent to the call of a surgeon.

These delayed cases necessitate drainage with a tedious convalescence, a weak abdominal wall and a homely scar.

Personally, I believe that appendicitis should always be considered surgical, although I admit that many cases recover spontaneously. But if I must compromise with these who differ with my radical view, what symptoms shall indicate the transition period? I claim that a case of appendicitis is imperatively surgical, if the temperature rises above 101, if the pulse rate is forty beats above normal, if there is continuance of pain, or if all symptoms do not abate after the bowels have been moved by salines. Or, in those cases where the pain subsides and the fever ascends (which means gangrene), or in any case of relapse; or in cases showing slight hebetude of mind, sluggish capillary circulation, retracted or disturbed rigid abdomen. These symptoms all point surely to perforation, gangrene, abscess, peritonitis and, if not treated surgically, death.

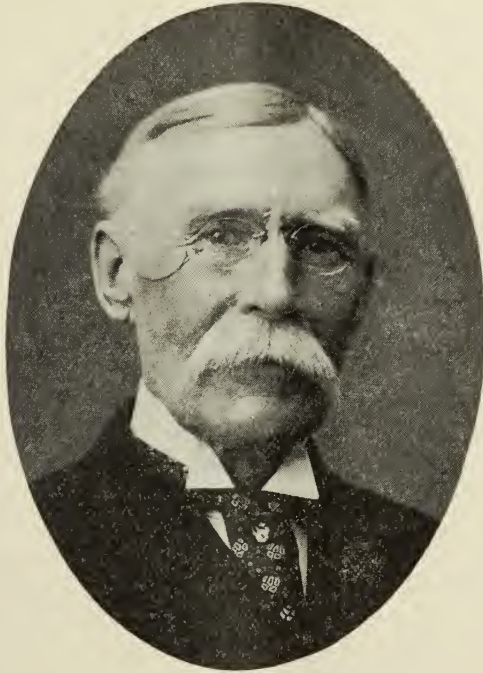
Gentlemen, our calling is one of terrible responsibility! Let us equip ourselves accordingly!

SURGICAL SUGGESTION.

Hemolysis tests are desirable before selecting a donor for transfusion, but if the case is of great emergency this may be dispensed with, since hemolysis is unlikely if the donor is free from malignant growth and tuberculosis. Syphilitic taint must of course be excluded.—*American Journal of Surgery*.

For Sale Instruments for throat and nose work, including a "Sass'" Laryngeal Stand, with globe inhaler, atomizing tubes and laryngoscope; also a John Robertson's Multiple Comminuter, compressed air tanks, a cautery, and books on ear, nose, throat and lungs. Apply

Mrs. Irving E. Kimball, 693 Congress St.



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WOOSTER PARKER GIDDINGS.

Dr. Giddings, the son of Thomas Giddings, Jr., and Lucinda Starrett, his wife, was born in Newburyport, Massachusetts, May 11, 1839, and died of pneumonia at Gardiner, Maine, after two weeks' illness, October 16, 1912. He was taken to China, Maine, when a mere child, then educated at Newburyport and New Hampton Academy, New Hampshire, with a view of entering college. At the age of twenty, however, he changed his mind and spent some years as an engraver in the Waltham (Massachusetts) Watch Factory, studying medicine at various intervals. He took a final course of lectures at the Harvard Medical School and was graduated there in 1871. He then practised briefly in Waltham, and obtaining a position as Medical Inspector on the Boston & Albany Railroad, he moved into Boston, where he practiced, served on the School Committee and successfully defended a damage suit, ultimately driving the plaintiff out of court.

His health became rather precarious in 1878, and whilst spending a vacation in Maine, he decided to settle in Gardiner about that time, and soon obtained an excellent medical and surgical practice. He was not an ordinary country practitioner, doing minor surgery, but he did many capital operations. Amongst these, I may cite a double ovar-

iotomy in New Brunswick in 1888; a very early appendectomy in 1892; and removal of an ovarian cyst weighing 144 pounds; whilst only three years ago, he did a hysterectomy for a fibroid which was so adherent as to require over a hundred ligatures. The growth itself weighed twenty-three pounds. At another time, he removed successfully, a myoma from a seven months pregnant uterus.

Dr. Giddings gradually rose high in public esteem and in that of the medical profession, so that in 1895 he was chosen President of the State Medical Association, delivering upon his inauguration a delightful address of welcome and of wisdom combined. During his membership in the Association, he read at intervals, papers of much promise, and during all of the meetings year after year, he entered into the debates with learning and precision of opinion. His papers showed a progressive mental development. Beginning with an ordinary subject like "Bright's Disease," he passed to "The Surgical Demands of a Country Practitioner," and then rose steadily through "Medical Experts before the Courts and their relations to each other." and "Physicians' Dangers in Damage Suits," to his best paper, "Body and Mind, with Incidental Reference to the Laws of Heredity."

He belonged also to the American Medical Association, was a prominent Mason, and was in the front in Gardiner, of late years, in favor of a better form of city government. He served often before the courts of Maine as a medical expert and labored diligently to obtain a better chance for physicians to speak out their real opinion as experts, in place of the unsatisfactory shuffling methods still in vogue, and owing to which physicians exhibit themselves unwisely with their ridiculous divergences of opinion.

He was a very able man, of wide experience and to the very end of his long and useful life he continued to increase in value to the community in which he lived and to this Association, whose meetings he so constantly attended. He leaves to mourn him, a widow, Adeline Florence Clark, and two children, one of whom, Dr. Harold G. Giddings, is a physician in Boston.

J. A. S.

CONSUMPTION OF SEWAGE.

Dr. Hurty said we consume more sewage than is good for us. The proof lies in the number of what we know as sewage-borne diseases, as typhoid, cholera, amœbic dysentery, bacillary diarrhœa, and possibly a number of other diseases not well defined — not only do they come from the consumption of sewage, but from the consumption of raw sewage.

The greatest public health problem in America today is the problem of sewage disposal. — *Florida Health Notes.*

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Editorial Comment.***The Composition of Epilepsy "Cures."***

Practically every "epilepsy cure" advertised to the public owes its effect to bromide. Thus Peeke's epilepsy cure was analyzed (Jour. A. M. A., Nov. 30, 1912, p. 1990) in the A. M. A. Chemical Laboratory and found to contain about 13.7 gm. sodium bromid and about 4.1 gm. ammonium bromid in each 100 c. c. The converse treatment for epilepsy when analyzed by the North Dakota Agricultural Experiment Station, was found to be a solution of the bromids of sodium, potassium, strontium, ammonium and iron, the total bromid content being equal to about 15.5 per cent potassium bromid. Regarding the brazenly asserted harmlessness of these preparations, the Journal A. M. A. (Nov. 23, 1912, p. 1911) says: "Practically every nostrum on the market sold for the self-treatment of epilepsy contains large quantities of bromids. These are taken by the patient in utter ignorance of the danger and in quantities that no physician with any respect for his patient's safety or his own good name would dare prescribe. Such heavy doses suppress the attacks but brutalize the patient and lead to a loss of mental and physical activity."

Eye-Strain Caused by "Movies."

Constant attendance at moving-picture shows may cause eye troubles similar to those of eye-strain. This statement is made by Dr. George M. Gould in a recent issue of *The Journal of the American Medical Association*. Dr. Gould says that he has recently made a practice of asking his patients, "What were you doing the evening

or afternoon previous to your headache or giddiness or upset stomach?" "Nothing at all," is the usual reply, "that is, nothing out of the ordinary. I was at the 'movies' for a couple of hours and went to bed as soon as I got home, as I was feeling badly." Dr. Gould warns physicians, oculists and nerve specialists to be on the watchout for such symptoms, and when found that attendance at moving-picture shows be considered as a cause. The symptoms, he says, do not differ greatly from those caused by strain or abuse of the eyes of any kind. The most common are those of sick headache, such as intense weariness of the eyes and brain, a dazed, "good for nothing" feeling, lack of energy and appetite, "upset stomach," vomiting, sleepiness and other effects. If the patient is wearing glasses, he may think "my glasses need changing." But on consultation with his oculist, it may be found that the glasses are all right, and that the cinematograph is to blame. But if the "movies" are not to blame, probably fitted glasses will enable the patient to attend moving-picture shows without discomfort. Without proper glasses, however, the cinematograph will more certainly cause nervous symptoms in the patient than when good glasses are worn, as there is no doubt that moving-picture shows put a terrific strain on even the least defective eyes, while the strain is increased by poor glasses or lack of glasses when they are needed. Dr. Gould says that the principal faults of moving-picture shows is that the "fixation point," chosen by the eye (that is the point on which the eye rests) is unstable and jerky and the eye is tired and strained in following this point. The swiftly passing series of pictures tires the eye and the brain, and the illumination is generally poor. To correct these faults, he suggests that the time of exposure of each image be shortened and that better illumination be required. The enormous growth of moving-picture shows in the last ten years and the adoption of the cinematograph for teaching and for various commercial uses, as well as its probable growth in the future, makes it important that the effect of moving pictures on the eyes should be carefully observed.

NOTICE.

Any member in good standing in the State Association, wishing to serve as a delegate to the meetings of other State Societies, should communicate with the President, Dr. R. H. Marsh, at an early date.

Medico-Legal Matters.

DISINFECTIONS AUTHORIZED BY THE UNITED STATES QUARANTINE REGULATIONS AND THE PROPER METHOD OF GENERATING AND USING SAME.

151. Burning. Of unquestioned efficiency, but seldom required.

152. Boiling. Very efficient and of wide range of applicability. The articles must be wholly immersed for not less than ten minutes in water actually boiling (10 C.). The addition of one per cent of carbonate of soda renders the process applicable to polished steel, cutting instruments or tools.

153. Steam. (a) Flowing steam (not under pressure). Flowing steam (not under pressure) when applied under suitable conditions is an efficient disinfecting agent. The exposure must be continued thirty minutes after the temperature has reached 100 C. (b) Steam under pressure without vacuum. Steam under pressure will sterilize, provided that the process is continued twenty minutes after the pressure reaches fifteen pounds per square inch. The air must be expelled from the apparatus at the beginning of the process. If impracticable to obtain the designated pressure, a longer exposure will accomplish the same result. (c) Steam under pressure with vacuum. Steam in a special apparatus with vacuum attachment is the best method of applying steam under pressure, the object of the vacuum apparatus being to expel the air and to promote the penetration of the steam. The process is to be continued for twenty minutes after the pressure reaches ten pounds to the square inch.

154. Sulphur dioxide is efficient, but requires the presence of moisture. It is only a surface disinfectant, and is lacking in penetrating properties. An atmosphere containing four and five-tenths per cent can be obtained by burning five pounds of sulphur per one thousand cubic feet of space. This amount would require the evaporation or volatilization of about one pint of water. Under these conditions the time of exposure should be not less than twenty-four hours for bacterial infections. A shorter time will suffice for fumigation necessary to kill mosquitoes and other vermin.

155. The sulphur may be burned in shallow iron ovens (Dutch ovens) containing not more than thirty pounds of sulphur for each pot, and the pots should stand in vessels of water. Quicker and better results can be obtained from burning the same total amount of sulphur in a number of small shallow ovens (Dutch ovens), five to ten pounds in each, than in a few large ovens. The sulphur ovens should be elevated from the bottom of the compartment to be disinfected in

order to obtain the maximum possible percentage of combustion of sulphur. The sulphur should be in a state of fine division, and ignition is best accomplished by alcohol; special care to be taken with this method to prevent damage to cargo of vessel by fire; or the sulphur may be burned in a special furnace, the sulphur dioxide being distributed by a power fan. This method is peculiarly applicable to cargo vessels.

156. Liquefied sulphur dioxide may be used for disinfection in place of sulphur dioxide generated as above, it being borne in mind that this process will require two pounds of the liquefied gas for each pound of sulphur as indicated in the above paragraphs.

157. Sulphur dioxide is especially applicable to the holds of vessels, or to freight cars and apartments that may be tightly closed and which do not contain objects injured by the gas. Sulphur dioxide bleaches fabrics or materials dyed with vegetable or aniline dyes. It destroys linen or cotton goods by rotting the fiber through the agency of the acids formed. It injures most metals. It is promptly destructive to all forms of animal life. This property renders it a valuable agent for the extermination of rats, insects and other vermin.

158. Formaldehyde gas is effective if applied by one of the methods given below. Formaldehyde gas has the advantage as a disinfectant that it does not injure fabrics or most colors. It is not poisonous to the higher forms of animal life. It fails to kill vermin, such as rats, mice, roaches, bedbugs, etc. The method is not applicable to the holds of large vessels. Formaldehyde is applicable to the disinfection of rooms, clothing and fabrics, but should not be depended upon for bedding, upholstered furniture, and the like, when deep penetration is required.

159. Many formaldehyde solutions do not contain forty per cent of formaldehyde, and all are apt to deteriorate with time. It is therefore necessary to use a quantity in excess of the amount prescribed in these regulations, unless the solution has been recently analyzed.

160. The following methods of evolving the gas may be used: (a) Autoclave under pressure, three to twelve hours' exposure. (b) Lamp generator, six to eighteen hours' exposure. (c) Spraying, twelve to twenty-four hours' exposure. (d) Formaldehyde and dry heat in partial vacuum, one hour's exposure. (e) Chemical, as formalin-permanganate method of Russel, (see par. 166); formalin-aluminum sulphate-lime of Walker, (see par. 166).

161. The minimum number of hours' exposure as given above applies to empty rooms of tight construction containing smooth, hard surfaces; the maximum number of hours' exposure applying in all

cases to textiles and other articles of a similar kind requiring more or less penetration.

162. Autoclave under pressure. This method has considerable penetrating power when applied as detailed below. Rooms or apartments need no special preparation beyond the ordinary closing of doors and windows. Pasting, caulking or chinking of ordinary cracks and crevices is not necessary. The doors of lockers and closets and the drawers of bureaus should be opened. In this apparatus use formalin (forty per cent), with the addition of a neutral salt, such as calcium chloride (twenty per cent). The gas must be evolved under a pressure of not less than forty-five pounds. After the gas is separated from its watery solution, the pressure may be allowed to fall and steam projected into the compartment to supply the necessary moisture. Use not less than ten ounces of formalin per one thousand cubic feet, and keep the room closed for three to twelve hours after the completion of the process. For large rooms the gas must be introduced at several points as far apart as possible. It is applicable to the disinfection of clothing and fabrics suspended loosely in such a manner that every article is freely accessible to the gas from all directions.

163. Lamp or generator. This method requires an apparatus producing formaldehyde by a partial oxidation of wood alcohol, and in using it the room or apartment should be rendered tight as practicable. Oxidize twenty-four ounces of wood alcohol per one thousand cubic feet, and keep the room closed for six to eighteen hours, in accordance with the provisions of paragraph 160. This method leaves little or no odor. When applied to clothing and textiles, the articles should be suspended in a tight room and so disposed as to permit free access of the gas. (See also par. 161). The wood alcohol should be of ninety-five per cent strength, and should not contain more than five per cent of acetone.

164. Spraying. The formalin (40 per cent) should be sprayed on sheets suspended in the room in such a manner that the solution remains in small drops on the sheet. Spray not less than ten ounces of formalin (40 per cent) for each one thousand cubic feet. Used in this way, a sheet will hold about five ounces without dripping or the drops running together. The room must be very tightly sealed in disinfecting with this process, and kept closed not less than twelve hours. The method is limited to rooms or apartments not exceeding two thousand cubic feet. The formalin may also be sprayed upon the walls, floors and objects in the rooms.

This method is markedly interfered with by and is not to be relied on at low temperature, say, below 72 F. At 43.5 F. very little formaldehyde is liberated, the formaldehyde being polymerized on the sheets.

165. Formaldehyde with dry heat in partial vacuum. This method has superior penetrating powers and is specially applicable to clothing and baggage. The requirements of this method are (1) dry heat of 60 C. sustained for one hour; (2) a vacuum of 15 inches; (3) formaldehyde evolved from a mixture of formalin with a neutral salt, in an autoclave under pressure, using not less than thirty ounces of formalin (40 per cent) for one thousand cubic feet; and (4) a total exposure, under these combined conditions, of one hour.

166. Chemical, as (1) Formalin permanganate method. When formalin is poured over crystals of permanganate of potash, a vigorous reaction takes place, and a large quantity of formaldehyde gas is liberated. Reaction is over in a short time, five minutes, and if a proper proportion of substances is used, the residue is almost dry. The proportion is two pints of formalin to one pound of permanganate of potash. One pint of formalin for one thousand cubic feet of space, should be used if the temperature is 60 F. or less, a less amount may be used for higher temperature, but not less than ten ounces per one thousand cubic feet. This method is extremely efficient on account of the rapidity with which the gas is liberated, but the danger of fire should be guarded against, as the formaldehyde gas, being in a comparatively dry state, is inflammable in the presence of a light, such as lighted matches, lamps, etc. (2) Formalin-aluminum sulphate-lime method. Add one part sulphate of aluminum to two parts of hot water. One part of this solution is added to two parts of formalin (both by volume). One part of this second solution is poured on two parts of unslacked lime (quick lime), broken into small particles. The process of liberation of formaldehyde gas is completed in about twenty minutes. This method is not as efficient as the previous one, as less than half the amount of formaldehyde gas is yielded from the same amount of formalin.

Two pints of formalin per one thousand cubic feet of space should be used, if the temperature is 60 F. or less.

Fire should be guarded against, but this danger is decidedly less than in the permanganate process on account of the large amount of water vapor coming off with the gas.

167. The stated times of exposure to sulphur dioxide and formaldehyde are sufficient to destroy bacterial infection due to non-spore-bearing organisms, providing that the infection is present on the surface. If the room is of peculiar construction, so as to impede the diffusion of the gas, or if the room is a dirty one, or if on account of any other condition rendering the germicidal action of the gas more difficult, the time of exposure should be proportionately increased, or supplanted by other methods.

168. Bichloride of mercury. Bichloride of mercury is a disinfectant of undoubted potency and wide range of applicability. It cannot be depended upon to penetrate substances in the presence of albuminous matter. It should be used in solutions of one to one thousand. The solubility of bichloride of mercury may be increased by using sea water for the solution, or by adding two parts per one thousand of sodium or ammonium chloride to the water employed.

169. Carbolic acid. Carbolic acid in the strength of five per cent (see par. 52) may be substituted for the bichloride of mercury, and should be employed in the disinfection of the cabins and living apartments of ships to obviate injurious action on polished metals, bright work, etc.

170. Formalin. Formalin containing forty per cent of formaldehyde may be used in a five per cent solution as a substitute for bichloride of mercury or carbolic acid, and is useful for the disinfection of surfaces, dejecta, fabrics and a great variety of objects, owing to its non-injurious character.

AGENTS FOR THE DESTRUCTION OF MOSQUITOES, RATS AND OTHER
VERMIN, AND THEIR APPLICATION TO QUARANTINE WORK.

181. Sulphur dioxide—obtained as described in paragraphs 154 and 155—destroys all animal life.

182. In the case of vessels, when treated for yellow fever infection, the process shall be a simultaneous fumigation with sulphur dioxide, two per cent volume gas, and two hours' exposure, in order to insure the destruction of mosquitoes.

183. In the case of vessels when treated for plague the process with sulphur dioxide shall be as follows:

Without cargo: The simultaneous fumigation with sulphur dioxide gas not less than two per cent for six hours' exposure.

With cargo: Fumigation with sulphur dioxide gas, four per cent, six to twelve hours' exposure, according to stowing.

Infected vessels may require partial or complete discharge of cargo, and fractional fumigation for efficient deratization.

184. Pyrethrum. The fumes of burning pyrethrum may be used to destroy mosquitoes in places where there are articles liable to be injured by the use of sulphur.

Four pounds per one thousand cubic feet space for two hours' exposure. With this amount all or practically all of the mosquitoes will be killed, but precautions should be taken to sweep up and destroy any that may have escaped.

Pyrethrum stains walls, paper, etc.

185. The oxides of carbon, as used at Hamburg, are efficient to destroy rats but do not kill fleas or other insects. They are obtained by burning carbon, coke or charcoal, in special apparatus, and the gas as produced consists of about five per cent carbon monoxide, eighteen per cent carbon dioxide, and seventy-seven per cent nitrogen.

Twenty kilos of carbon, coke or charcoal are used for every one thousand meters of space. The gas is allowed to remain in the ship for two hours and from seven to eight hours are allowed for it to leave it. This is about equivalent to one and one-third pounds of carbon (coke) to one thousand cubic feet of air space. As this gas is very fatal to man and gives no warning of its presence, being odorless, a small amount of sulphur dioxide should be added to give warning of its presence. As it does not kill fleas it can not be depended on for complete work, where there is evidence of plague among rats on the vessel, as the infected fleas would infect the rats coming aboard after the deratization.

186. The articles named as disinfectants which can obviously destroy animal life, can be used for that purpose when applicable as steam for bedding, fabrics, etc. Formaldehyde is not applicable for this purpose.

187. Where both disinfection and destruction of vermin are required for mattresses, pillows and fabrics, the use of steam meets both requirements, and is especially applicable.

188. Hydrocyanic acid gas is fatal to all forms of animal life and is not injurious to any material. It is best generated by mixing cyanide of potash, four parts; sulphuric acid, six parts; water, nine parts. The acid should first be diluted, which must be done in some vessel capable of withstanding the heat. The whole amount of the cyanide of potash must be put in the acid at once, and as the evolution of the gas is very rapid, the operator must be prepared to leave immediately. Fulton advised that the cyanide be tied in a bag, to be lowered into the acid by a cord passing outside of the room.

About ten ounces of cyanide of potash per one thousand cubic feet. It is of course applicable when necessary to destroy mosquitoes or vermin (particularly in living quarters), but is too dangerous to be used except by those experienced in its use, and then under most rigid precautions. Though destructive to animal life, hydrocyanic acid gas is but of slight value as a germicide.

SURGICAL SUGGESTION. •

When operating upon a carcinoma of the stomach, be sure to suture the layers of the abdominal wall with silk or linen. In these cases healing is very slow and the wound may burst open if absorbable sutures are used. — *American Journal of Surgery*.

Foreign Notes.

Wochenschrift fuer Therapie und Hygiene des Anges.

How an instance of hospital abuse was financially assessed. A letter from Paris says: "Physicians are always talking of the abuse of hospital charity and a recent instance is worth repeating. The Secretary of a syndicate of French oculists belonging to the staff of a recently established eye hospital discovered a woman of large property enjoying as a poor patient a free bed in which she obtained gratuitously, a successful operation for cataract. The Syndicate brought suit to recover damages on the ground that the woman had deprived some poor person of the use of the free bed, and had also obtained fraudulently the skill of the attending surgeons, for which she was abundantly able to pay. The judge decided that the woman should pay one thousand francs damages and costs and the French minister of the Interior decided that half of the sum should go to the funds of the hospital and half to the benefit fund for the families of the attending surgeons in case of need.

Epistaxis.

If you stand behind a patient so affected with your hands beneath the inferior maxillary, and then draw the head upward and backward steadily and evenly and continued this for a short time, it is claimed by Naegeli that obstinate nose bleeding can be made to cease. The idea is that the hemorrhage ceases owing to irritation of the vasco constrictors caused by thus stretching the cervical sympathetic.

Excessive Hemorrhage After Tenotomy of the Internal Rectus.

A German oculist divided the internal rectus of a delicate looking boy of five for simple convergent strabismus, at eleven in the morning and sent the child home with the eye bandaged, as there was no bed for him in the hospital. At two in the afternoon, word was sent that the bandage was soaked through with blood and when the surgeon arrived and removed it, the condition of affairs was something terrible to behold; the lids were swollen so as not possibly to be opened at all, and the entire face was transformed into an enormous haematoma, as it might be called. For, not only was blood trickling down over the face, but it had leaked down under the tissues and colored them a bright violet. All attempts made to reach the bleeding vessel failed. Whether ligation of the carotid or compression of that vessel were attempted or not, the report does not inform, but ice bags were em-

ployed for four entire days and nights incessantly. In spite of them the bleeding continued and the child seemed exsanguinated and comatose. Finally, on the fifth day the bleeding slowly ceased and from that time onward recovery was slow but sure. Two days later the eyelids could be opened when to the delight of the parents the eyes once so crossed were now and remained perfectly straight. They had been well repaid for their frightful experience.

Two similar cases have been reported, but in those there seemed hereditary haemophilia, while in the present instance it could only be discovered that when the child was four years old, he struck a chair and had on his leg for a long time a violet colored swelling and scar.

J. A. S.

Book Reviews.

A Text Book of Obstetrics.

Including Related Gynecologic Operations. New (Seventh) Edition. By Barton Cooke Hirst, M. D., Professor of Obstetrics in the University of Pennsylvania. Cloth, \$5.00 net. W. B. Saunders Company, Philadelphia, London.

Perusal of this really new work shows many changes from the past editions, and these are improvements. As before, this volume contains much material not found in other text-books on obstetrics, and yet this is all subject matter which comes to the obstetrician in his practice. While not hoping to compete with a complete work on gynecology, consideration of these subjects is taken up in no cursory manner. Although there are several points of procedure outlined which the reviewer cannot uphold as best to follow, the work as a whole is most instructive, and particularly in regard to minor points which are so often allowed to go by default is knowledge gained in the reading. The general make-up of the book, and the excellence of the frequent cuts is wholly to be commended.

H. J. E.

Physicians' Visiting List, 1913.

Sixty-second year of the publication. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

The usual complete little booklet containing tables of signs, incompatibility, poisoning, metric or French decimal system of weights and measures, etc., also visiting list with special memoranda, for twenty-five patients per week.

Review of Current Literature.

(International Surgery, August, 1912.)

A New Effective and Rational Method of Selecting Amputation Levels.

BY W. R. MCKINLEY, M. D., COLUMBUS, MISS.

The author claims that in every amputation in cases of gangrene, the operator is confronted with the proposition of selecting the site, except those who work by a fixed rule. As for example, in lower extremities, the tendency is to amputate below the knee, at the knee-joint or above the knee, just as the operator's judgment permits, and often times fearing the possibilities of having to amputate the second time a much higher level than need be is sought.

Dr. McKinley says, that the causative factor of gangrene always lies in the blood-vessels, especially the arteries, therefore should be used as a guide.

His method to determine the level for amputation is to dissect out each blood-vessel from below upwards. At the beginning of the dissection the blood vessels are found not to be functioning properly or obliterated. Following each blood-vessel up by careful dissection, he is able to determine the point of vascular obstruction and the efficiency of the blood supply. After proving to himself by the blood-vessels already dissected that he has reached the level of vascular trouble, this marks the site of amputation.

Six amputations have been performed by the writer using this method with good results. The advantages he claims for it in each case are that it lessens the danger of a second operation, that there is no flap necrosis, and furthermore a much lower level for amputation is found with a greater conservation of tissue.

E. H. J.

Thyroid Extract in Nephritis.

J. F. Percy, M. D., Galesburg, Ill.

A presentation of thirty-five cases, and minute study of two cases with nephritis, showing the usual signs of scanty urine, various amounts of albumen, high blood pressure, put upon treatment by tablets of thyroid extract, together with, or to exclusion of other remedial agents, and getting remarkable results. These were particularly noticed in the reduction of the blood pressure, elimination completely of the albumen, and increase in the amount of kidney excretion, and in conjunction with these was a great general improvement in the condition of the patient.

H. J. E.

County News.

CUMBERLAND.

PORTLAND MEDICAL CLUB.

The annual meeting was held at the Falmouth Hotel, December 5. Four doctors were elected to membership, Drs. Baldwin, Jackson, Swift and Young. Annual reports were made by the secretary and president, and officers were elected for the next year, as follows:

President, Dr. Harold A. Pingree; 1st Vice President, Dr. Walter D. Williamson; Second Vice President, Dr. A. Mitchell, Jr.; Censors, Drs. Dunn, Weeks and Files; Secretary and Treasurer, Dr. Roland B. Moore; Orator for 1913, Dr. Owen Smith.

The essays for the regular meeting of the year were also assigned.

After a substantial dinner served in the State of Maine Room, Dr. Addison S. Thayer took for the subject of his oration, "The Privileges, Opportunities and Duties of the Medical Man in Portland Today." His talk received attentive reception, and was followed shortly by a free discussion of medical conditions in this city, especially as regards the management of the Board of Health and allied conditions. This became very interesting, and continued to a late hour.

The first meeting of the new year will be a symposium by men who have had service in regulating health conditions in Portland as to present needs, and ways of obtaining them.

H. J. EVERETT, *Secretary*.

ANDROSCOGGIN

The annual meeting of the Androscoggin County Medical Association was held on December 3rd in the Court room at Lewiston city building, Dr. Call in chair.

A Committee was chosen by the Chair to bring in names for officers of the society for the coming year.

Dr. Wallace Webber, Dr. Edson Cummings and Dr. W. S. Garcelon constituted the committee and presented names as follows, all of whom were elected:

President, Dr. W. L. Haskell; Vice President, Dr. J. W. Scannell; Secretary and Treasurer, Dr. S. E. Sawyer; Executive Committee—Chairman, Dr. A. W. Plummer, Dr. Edson Buker, Dr. J. E. Dupras; Delegate to State Society for two years, Dr. E. V. Call.

A case history furnished by Dr. H. E. E. Stevens was discussed by the members present.

Several of the older members of the society spoke of various customs during its early days and it was decided that in the future, the retiring president should present a paper at the last meeting of his term of office.

S. E. SAWYER, *Secretary*.

FRANKLIN.

The annual meeting of the Franklin County Medical Society was held in Farmington, November 25th, 1912.

The following were elected officers for 1912:

President, B. F. Makepeace, Farmington; Vice President, O. B. Head, New Sharon; Secretary, G. L. Pratt, Farmington; Treasurer, J. W. Perkins, Wilton; Delegate to State Association, A. G. Howard, Farmington; Censor for three years, A. J. York, Wilton; Censor for two years, E. J. Brown, Stratton.

Dr. Dorris M. Presson of Farmington, who is in Baltimore for the winter, was elected a member of the Society.

A very interesting paper was read by Mr. Henry D. Evans of Augusta, on the work of the State Laboratory of Hygiene.

GEORGE L. PRATT, *Secretary*.

HANCOCK.

The annual meeting of the Hancock County Medical Society was held at the residence of Dr. R. W. Wakefield, Bar Harbor, December 18. The President, Dr. R. G. Higgins, in the chair. The minutes of the last meeting were read and approved. Dr. I. B. Gage of Swan's Island was accepted as a member of the Society and an application for membership was received from Dr. Underhill.

The following were elected as officers for the ensuing year:

President, Frank R. Ober, Northeast Harbor; Vice President, E. J. Morrison, Bar Harbor; Secretary and Treasurer, Geo. A. Neal, Southwest Harbor; Censor, J. H. Patten, Bar Harbor; Delegate to State Association, Lewis Hodgkins, Ellsworth; Legislative Committee, J. H. Patten, Geo. R. Hagerthy and J. D. Phillips.

Dr. H. B. Webster of Castine, read a very interesting paper on "Morphinism: Its Probable Pathology and Rational Treatment." The paper was discussed by all present.

At the conclusion, we adjourned and were served an excellent repast by our host.

FRANK R. OBER, *County Editor*.

KENNEBEC.**AUGUSTA MEDICAL CLUB.**

The annual meeting of the Augusta Medical Club was held Monday evening, December 9th, 1912, at the Augusta House. The following officers were elected:

President, W. S. Thompson; Vice President, George E. Coombs; Secretary and Treasurer, Dr. H. W. Miller; Standing Committee, Dr. A. H. Sturtevant, Dr. H. W. Sampson and Dr. Roland L. McKay.

The scientific program consisted of cases reported by the various members and a talk upon the New Psychopathic Hospital in Boston, by Dr. S. E. Vosburgh, the newly appointed first assistant physician at the Maine Insane Hospital.

HENRY W. MILLER, *Secretary*.

KNOX.

The annual meeting of the Knox County Medical Society was held in Rockland, December 12th.

The following officers were elected for the ensuing year:

President, B. F. Adams, of Rockland; Vice President, E. B. Silsby, of Rockland; Secretary and Treasurer, H. W. Frohock of South Thomaston; Censor for three years, W. F. Hart of Camden.

Clinical cases were reported by Drs. Hart, Adams, Silsby and Coombs.

Dr. Fred Campbell of Warren, and Dr. Carleton Stuart of Rockport, were unanimously elected to membership in the Society.

It was voted to hold the next meeting at the Thorndyke Hotel, Rockland, on the second Tuesday in February, at 6.30 o'clock, P. M.

The majority of the members thought it would be more convenient to have all future meetings in the evening.

H. W. FROHOCK, *Secretary*.

SAGADAHOC.

The Sagadahoc County Medical Society held a meeting at Colonial Cafe. As special guest of the Society, E. W. Gehring of Portland read a paper, "Concerning the Importance of Details in the Practice of Medicine."


Dr. Enoch Leathers of Wiscasset was elected as a new member.

The following officers were elected for the ensuing year:

President, I. C. Irish, Bowdoinham; Vice President, A. A. Stott, Woolwich; Treasurer, R. H. Donnell; Secretary, R. C. Hannigan; Delegate: A. F. Williams, Phippsburg; Censors, C. A. Peaslee, A. A. Stott.

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WASHINGTON.

The annual meeting of the Washington County Medical Society was held in the city rooms, Calais, Thursday, December 13th, at one o'clock, P. M.

The papers of the evening were read as follows:

Dr. G. O. Dibblee, Moore's Mills, "A History of Cases Treated by Tuberculin;" Dr. W. J. Gilbert, Calais, "To do, and not to do in Eye Diseases;" Dr. E. V. Sullivan, St. Stephen, "Blood Examination; its Aid in Diagnosis;" Dr. S. E. Webber, Calais, "Obstetrics in Private Practice."

H. B. MASON, *Secretary.*

YORK.

The 19th annual and 71st quarterly meeting of the York County Medical Society will be held in Odd Fellows Hall, Biddeford, Thursday, January 9th, at 10 o'clock A. M. This will be the annual meeting for the election of officers. A paper on "Glaucoma" will be presented by Dr. H. A. Little of Portland. A question box will be conducted, and

a Dutch lunch will be served at the close of the literary program. It is hoped and expected that there will be a large attendance.

A. L. JONES, *Secretary*.

PERSONAL NEWS AND NOTES.

Major Clarence F. Kendall, M. D., Biddeford, gave a talk, Wednesday evening to the members of the Seventh Company C. A., on first aid to the wounded. The major is a member of the medical corps of the State establishment and officers of this corps give talks of the kind at least twice a year to companies.

Sanford, December 19.

John Philpot, who has the smallpox, is seriously sick. The other patients, of whom there are twenty-five, all have a mild form of the disease. The print shop of the Sanford mills re-opened Tuesday after thorough fumigation. Every employe in the department was vaccinated. So far, every case has been in a home where the patient could be treated. Dr. R. L. McKay of Augusta, was sent here by the State board of health, last week and commended the Sanford board of health for the measures they were taking. He was active in Augusta,, last winter where there were sixty cases of smallpox and gave our health board the benefit of his experiences.

Every person who is out of any department of the mills is looked up and, if sick, the case investigated. In this way, the situation is pretty thoroughly canvassed, and although the majority of absentees have some other reason for absence, still, every likely case is known.

Albert K. Baldwin, M. D., announces the removal of his office from 909 to 929A Congress Street.

Dr. Stephen E. Vosburgh has been appointed first assistant physician at the Maine Insane Hospital, to take the place of Dr. Carl J. Hedin, who resigned to accept the Superintendency at the Maine School for Feeble-minded. Dr. Vosburgh is a graduate of the Jefferson Medical College and has had a wide experience in general and insane hospitals. He comes to Maine after serving in the new Psychopathic Hospital in Boston.

Dr. Witham of Westbrook is recovering from a badly infected hand.

Drs. W. Bean Moulton and Owen Smith of Portland, are convalescent, after an attack of the grippe.

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Notice from members regarding sale of practice, merchandise, etc., should be sent in early and specify the number of insertions.

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THE PRESENT STATUS OF MODERN OBSTETRICS.

BY DR. EDWIN CRAGIN, OF NEW YORK.

Mr. President and Members of the Maine Medical Association:

No one can undertake the task of presenting to a State Society of a sister State the subject chosen for this evening without being impressed with the honor conferred in the invitation to undertake the task and, at the same time, with the responsibility involved in the undertaking.

The speaker realizes, however, that the criticism of earnest seekers after truth is kindly, and kindly criticism is one of the greatest stimuli to progress. He would therefore endeavor to present to you the results of experience with the methods adopted at the Sloane Hospital for Women, until recently known as the Sloane Maternity, New York City, an institution he has served for many years.

The position of obstetrics today differs widely from that occupied by this branch of medicine a century ago. The days when the obstetrician was looked upon as simply a man midwife have passed, and the stages of development of the specialty are interesting to trace.

It was only natural that the obstetrician and the Professor of Obstetrics in our medical schools should at first be an outgrowth of the general family physician, and that the chair of Obstetrics in some of our colleges should have combined with it the Chair of Diseases of Children.

Gynecology, too, was then largely non-operative, and was often included in the same chair. With the life and work of McDowell, Sims, Thomas and Emmet in our own country, and that of Keith,

Schröder, Tait and others in Europe, Gynecology developed along surgical lines, attracted to itself the younger generation of medical men and separated from obstetrics which in many instances was practiced and taught by men with little or no surgical training. Of late years a marked change has taken place in obstetrics, and it too has developed along surgical lines, and obstetrics and gynecology after being divorced for many years, are now wooing and re-wedding as is evidenced by the union of the two chairs under one head in many of our colleges today. As indicated above, the recent developments of obstetrics have been along surgical lines and it requires no great prophetic eye to see that the skilled obstetrician of the future must be the obstetric surgeon, with surgical as well as obstetrical training, who is able to deal with all complications of obstetrics, whether it be an ectopic gestation, or a ruptured uterus and whether the case needs a high forceps operation or a Cæsarean section.

This means that the obstetrician must be at home not only in the use of his hands and the obstetric forceps, but in the use of the knife, the scissors, needles and needle holder, and the other instruments of the surgeon's armamentarium.

Coming now to the different phases of modern obstetrics, there are four conditions which either in his own practice, or in consultation, every obstetrician of experience may be expected to face. Infection, Hemorrhage, Toxemia, and Dystocia and the discussions of how best to meet the problems presented by these conditions may well occupy our time and thought this evening.

INFECTION. Of course the best way to solve the problem of infection in obstetrics is not to have any, and too much stress cannot be laid upon Prophylaxis. With the sturdy constitutions and the pure air of the broad State of Maine, you may see little puerperal infection: in fact many of you may have gone through a long obstetric experience without meeting in his own practice with a single case of serious puerperal infection. Yet those of us who are so unfortunate as to live in a crowded city like New York are obliged to admit that puerperal infection occasionally occurs even in the hands of good men, and that it is only by the most rigid prophylactic methods that it can be avoided.

Most obstetricians are agreed to-day that occasionally cases of puerperal infection occur in which the obstetrician is not in the slightest degree responsible for the condition.

A toxic woman may have an accidental hemorrhage. The uterus of a woman whose vitality is reduced by hemorrhage does not contract well and in spite of precautions, small clots may be retained. This may give rise to a toxemia, or sapremia, and if this woman is carrying

pathogenic germs in any part of her parturient canal as in cervix, Skene's ducts, or Bartholin's ducts, the sapremia may be followed by a septicemia without the obstetrician being in any way responsible for it. Again a woman may have a normal temperature and pulse for a week or later, and a stenosis at the internal os, perhaps produced by a flexion may then cause a retention of lochia with a sapremia which may be the starting point of a septicemia as above. These conditions are recognized by the profession, but so well have the laity been educated to the idea that puerperal infection is caused by lack of precautions on the part of the obstetrician, that if he would avoid the criticism of the laity, often the most bitter of any, there is only one course open to him, viz: to use every precaution known to science. This brings us to the use of rubber gloves in obstetrics.

Many argue that they have delivered cases for years without gloves and without losing a case. That may all be so, but in New York at least it is not safe for a man to deliver a case without rubber gloves, for so thoroughly have the laity been impressed with the idea that the use of sterile rubber gloves is the best means of avoiding infection of the parturient canal by dirty fingers, that if any infection does occur and gloves have not been used, the obstetrician is at once branded as careless and the cause of the trouble.

So long as an obstetrician employs every precaution known to science, even if infection does occur in his practice, he can count on the support of the profession, but woe to the man who thinks his methods, with incomplete precautions, are sufficient. He has the support neither of the profession nor of the laity, and it may be added, he deserves neither.

Before leaving the subject of prophylaxis against infection one fact should be borne in mind. No matter how clean the hands are, and no matter how sterile the gloves which cover those hands, the labia and the skin perineum are not sterile and it is an easy matter, if the labia are not well separated before introducing the gloved examining fingers, to carry infection, from the non-sterile vulva without, to the sterile vagina the cervix within. It is unnecessary to state to this audience that the prophylactic antepartum vaginal douche has been abandoned as not only unnecessary, but tending to lessen nature's safeguards against infection.

As regards the actual treatment of puerperal infection when once established our progress has not been great and may perhaps be summed up in the recognition of the value of the adoption of two rules.

1. DO NOT HANDICAP NATURE IN HER ATTEMPTS AT CURE.
2. ASSIST HER ALL YOU CAN.

One of the ways in which we have, until recently ignorantly if

not innocently, handicapped nature in her attempts to cure puerperal infection has been to consider that every case of puerperal infection indicated a curettage of the uterus. We recognize to-day that the very barrier presented by nature to the spread of pathogenic organisms from the uterine cavity into the general system may be broken down by a curettage and an infection, which might have remained localized in the uterus as a toxemia, becomes a general bacteremia through the curettage employed with good intent, but poor judgment.

If there is no retained organic material in the uterine cavity, a curettage does immeasurable harm by opening new avenues of infection and spreading the pathogenic organisms, as is evidenced by the rigor and sudden rise of temperature which often follows the operation. If there is organic material retained in the uterine cavity as blood clots, portions of placenta, etc., these should be removed, as a sapremia may easily lead to a septicemia, but this removal should be accomplished in the gentlest manner possible and with the least traumatism of the uterine wall.

The question naturally arises what is the duty of the obstetrician when face to face with a rise of temperature in the puerperium which by exclusion of the condition of bowels, breasts, kidneys and appendix, he is forced to assign to the uterus? If the case has been under his care during the parturition and he knows that all aseptic precautions have been employed at delivery, the use of the hot saline vaginal douche, with solution and apparatus absolutely sterile, twice a day, for twenty-four to forty-eight hours, with the hope that under the influence of the vaginal heat the uterus will contract and expel its contents, is I believe good practice. If at the end of this period the temperature is not steadily decreasing, a gentle intra-uterine douche of sterile salt solution, with douche nozzle held quietly after introduction into the uterus, will usually remove loose organic material and accomplish the desired result.

If the temperature does not improve after one intra-uterine douche, or if you are not sure of the technique of the delivery, as in a case seen in consultation, or brought to your service in a hospital, a gentle exploration of the cavity of the uterus under anæsthesia is indicated.

This, as already pointed out, should be as gentle as possible and, in my experience, the gloved finger is the best instrument, although a loop ended sponge holder, or a fairly rigid, blunt curette, may be substituted for it. When once the uterus is emptied and the debris washed out, it should be left alone. Frequent douching of the uterus when there is nothing to wash away does no good and by its traumatism does harm.

So far we have been trying to carry out the first rule mentioned above, viz: Do not handicap nature in her attempts at cure. Now for the second: ASSIST HER ALL YOU CAN. The fresh air treatment so well recognized as a means of increasing resistance in tuberculosis, has come to be looked upon as a most valuable aid in puerperal infection, and the wide open windows, or the roof garden, are now adopted as one of the first steps in the treatment.

Regarding the use of sera and vaccines, we have met with many disappointments. During the acute state of puerperal infection the speaker has been unable to convince himself that his case has been benefitted by vaccines, or by the intra-venous or sub-cutaneous injections of sera.

When the case has become subacute, vaccines in a few cases have seemed to help, but not with sufficient uniformity in the hands of different men to prove themselves of marked value.

When there is marked superficial necrosis along the course of the parturient canal, the loose packing of this canal with gauze soaked in a polyvalent antistreptococcic serum has in my experience served to hasten the clearing of the surface and so lessen the absorption.

Arguing from the benefit derived from operation upon the lateral sinus and internal jugular vein in certain cases of extensive suppurative otitis media, certain obstetric surgeons have within the last few years advocated the ligation, or ligation and removal of the thrombosed pelvic veins in puerperal infection with or without removal of the uterus.

The question of the wisdom or advisability of this procedure is still subjudice and the cases reported too few to justify conclusions, but so many of these cases of puerperal infection recover without operation that when one considers the difficulty in diagnosing a localized pelvic thrombo phlebitis and the risk of subjecting to a radical operation a woman who may recover if her vitality is conserved rather than overtaxed, it must be evident that the indications for these operations in puerperal infection are not frequent.

Any localized collection of pus in the uterine wall, in the cellular tissue, or in the appendages, occurring in the puerperium indicates surgical interference, but this indication usually appears in the latter rather than the early part of the puerperium.

The treatment of puerperal infection today then may be summed up as follows:

1. The strictest prophylactic cleanliness.
2. The gentlest cleaning of the uterus, if not already empty.
3. The conservation of the patient's resistance in every way possible.

4. The drainage of pus collections if present with the least radical surgery possible.

HEMORRHAGE: POSTPARTUM, UNAVOIDABLE, ACCIDENTAL. The question of postpartum hemorrhage has for years been so well understood and so little has been added to our knowledge of this condition of late that I shall only emphasize the principles of treatment, both prophylactic and curative which most maternity hospitals have adopted today.

PROPHYLACTIC. 1. The avoidance of over fatigue of the uterus by a too long second stage of labor.

2. The assurance that the uterus is emptied.

3. The maintenance of uterine contractions by careful holding and guarding of the fundus for one hour after delivery.

CURATIVE. Accurate diagnosis of source of hemorrhage — relaxed uterine body, or lacerated cervix. Gauze packing in former. Suture in latter. Infusion of saline solution, or, in desperate cases, direct transfusion of blood.

One feature of the uterus in this connection may well be mentioned. After a woman has lost a certain amount of blood, the uterus and its vessels lose their power of contraction and the blood its power of rapid coagulation. These are the cases which even after firm packing of the uterus with gauze, will ooze and ooze, and a saline intravenous infusion by increasing intravascular pressure will sometimes make them ooze the more. Here it is that the direct transfusion of blood gives us hope for the future.

The routine treatment of placenta previa with its so-called "unavoidable hemorrhage," as practised at the Sloane Hospital, is with the use of the Voorhees modification of the Champetier de Ribes elastic bag shown in the drawings.

This use of the bag is seen to be extra ovular and the objects of its use are to control hemorrhage and at the same time to dilate the cervix so that when the large sized bag passes the cervix, the labor can be terminated, usually by a version.

Our maternal mortality in placenta previa at the Sloane Hospital by the use of this method of treatment has been as follows: In the last seven thousand deliveries in which the elastic bag has been the method employed to dilate the cervix and control the bleeding, there have been seventy-one cases of placenta previa, with a mortality of seven, i. e., 9.86 per cent. Of these seventy-one cases, fifty-three were of the incomplete and eighteen of the complete variety. Of the former, two died, giving a mortality of 3.77 per cent, although both died of conditions other than the placenta previa: one dying of sepsis after a Cæsarean section performed on account of a flat pelvis as-

sociated with placenta previa, the other dying of a toxemia with necrosis of the liver.

In the eighteen cases of the complete variety, there were five deaths, giving a mortality of 27.77 per cent. This unusually high mortality was caused by the fact that two of the five cases were brought to the hospital in bad condition, one being nearly moribund on admission and living only thirty minutes after reaching the hospital.

The phase of obstetric hemorrhage of which the speaker is free to confess that he stands most in awe is the so-called "accidental hemorrhage" near term. A hemorrhage perhaps entirely concealed within the uterus, associated with a separation, perhaps a complete separation of a normally situated placenta. The woman is usually toxic, for a toxemia usually lies behind this accidental hemorrhage. She is in shock, for the stretching of the uterus over the placenta site gives a shock all out of proportion to the amount of blood lost. She is anæmic from her loss of blood, and now to add to your discomfiture and her danger, she may have an undilated rigid cervix.

The only factor in the problem which at all favors its solution is that the child is usually killed by the hemorrhage and fetal life does not have to be considered in the delivery.

The barrier to the rapid delivery of the patient and landing her on safe ground is usually the cervix. If the cervix was dilated or dilatable, a craniotomy could be done if necessary and delivery expedited in this way. But here lies the problem. How can we best dilate the cervix? Our experience at the Sloane Hospital leads us to favor the use of the Voorhees bag to soften and dilate the cervix while the woman is rallying from her shock, perhaps aided by a saline infusion or a direct transfusion, and when the dilation or dilatability has been secured, the rapid delivery of the woman followed by the tamponade of the uterus with gauze. In exceptional instances where the cervix is very long and rigid the vaginal Cæsarean section finds a useful field, but when considering the advisability of an abdominal or a vaginal Cæsarean section in cases of accidental hemorrhage near term, it must be remembered that the woman is already in shock as well as toxemic and delivery with the least additional shock is the procedure of choice.

TOXEMIA. There is no recent problem of obstetrics which has so aroused the interest and study of both pathologist and clinician as that of toxemia of pregnancy, whether it shows itself in pernicious vomiting, in threatened eclampsia or in a typical eclamptic seizure.

Our knowledge of its etiology is limited and we can only say that it is due to some toxin or toxins circulating through the system and that with this there is associated some fault in the elimination of the products of metabolism.

Our knowledge of the pathology of the toxemia of pregnancy is of comparatively recent date, but thanks to the work of Jurgens, Schmorl, Williams, Ewing and others, the lesions are now well recognized and generally accepted.

The changes are chiefly those of congestion, hemorrhage, parenchymatous degeneration and necrosis. The liver and kidneys are the organs chiefly involved and the lesions may vary with the clinical type. Thus in those cases characterized by vomiting, jaundice, a tendency to hemorrhage with little edema and slight albuminuria, the liver is the organ most involved, while in those characterized by headache, high tension pulse, marked disturbance of the nervous system, marked albuminuria and edema, the kidney changes are more marked.

Of course many border line cases present themselves in which both the liver and the kidneys are involved, but in every large maternity service the two distinct clinical types are often seen.

The lesions in the liver vary from granular and fatty degeneration to necrosis with almost complete dissolution of the liver parenchyma.

This necrosis begins at or near the center of the lobule and extends toward the periphery, leaving perhaps only a mass of granular detritus surrounding the central vein. Thromboses with hemorrhage occur throughout the lobule, more often at the periphery.

The kidneys are swollen, the cortex thickened, pale and congested, the markings less distinct and the capsule not adherent. Microscopically the cells of the cortical tubules are swollen, in many places disintegrating.

If asked what advances have been made in recent years in the treatment of toxemia of pregnancy, the speaker would reply as follows:

1. The recognition of the serious liver lesion in the pernicious vomiting of pregnancy, and along with this the wisdom of early emptying of the uterus before the liver lesion becomes irreparable.
2. The recognition of the importance not only of frequent analysis of the urine for albumin and casts, but for the evidences of faults in metabolism, especially proteid metabolism.
3. The recognition of the importance of watching the blood pressure of pregnant patients and of looking with suspicion upon a blood pressure above one hundred and forty in a pregnant patient.
4. The recognition of the fact that the liver lesion in delayed chloroform poisoning in man and in chloroform anæsthesia in dogs closely resembles the liver lesion in pernicious vomiting and in eclampsia, and that therefore it is irrational to administer chloroform to a toxemic pregnant or parturient patient.

The clinical value of this knowledge may be seen in the results of the treatment of eclampsia at the Sloane Hospital during the period when chloroform anæsthesia was the rule and during the period when chloroform in all forms of toxemia has been abandoned and ether employed when any anæsthesia is required.

In the series of 20,000 deliveries when chloroform was used there were 251 cases of eclampsia with a mortality of 71, i. e., 28 per cent.

Since chloroform has been abandoned in toxemia and ether employed there have been 4,748 deliveries, with 56 cases of eclampsia, with 6 deaths, or 10.71 per cent, a mortality of less than half that in the series when chloroform anæsthesia was the rule in toxemia and eclampsia.

The principles guiding the treatment of toxemia threatening eclampsia at the Sloane Hospital are as follows:

1. The products of metabolism requiring elimination should be reduced.

2. Elimination of metabolic products should be favored.

3. High blood pressure should be reduced.

4. If the toxemia of the patient, as shown by the urine, blood pressure and general condition, does not markedly improve under the preceding principles of treatment, or if an eclamptic seizure occurs the uterus must be emptied.

5. In all methods of treatment that should be avoided which will either reduce the resistance of the patient or seriously damage any of her organs.

Let us now consider these principles more in detail.

1. In reducing the products of metabolism requiring elimination the obstetrician is brought face to face with the problem of diet for the toxemic patient. As proteid metabolism is that most often at fault, it is generally agreed that red meats should be avoided in all forms of toxemia of pregnancy and the puerperium. Although in mild degrees of toxemia, chicken and fish may be allowed, in severe forms of the condition an exclusive milk diet with large draughts of water is the diet of choice to which are added cereals, chicken broth, fruits and green vegetables, as the toxemia diminishes. As a prophylactic measure it is our custom, during the last month of a normal pregnancy, to allow the ingestion of red meat only two or three times a week.

2. In favoring the elimination of products of metabolism, the three avenues, the skin, the urinary tract and the intestinal tract, should receive careful attention. Thus elimination through the skin by sweating, induced either by the hot air bath or the hot wet pack, is a most useful measure in the treatment of toxemia. Elimination through the

urinary tract, favored by the ingestion of large amounts of water, and elimination through the intestinal tract, favored by calomel and saline or other laxatives, and especially by colon irrigations with saline solution, are methods which are considered routine procedure in the treatment of this condition.

3. In the reduction of blood pressure while venesection is the choice of many obstetricians, and was formerly quite extensively employed at the Sloane Hospital, its use has now been superseded by veratrum viride, nitroglycerine and chloral, and with better results. Our methods of using these drugs in toxemia threatening eclampsia is as follows: Chloral (30 grains) is administered per rectum as an initial dose, and then repeated in doses from twenty to thirty grains from every four hours to every six hours, according to the restlessness of the patient. Nitroglycerine gr. 1/50 to gr. 1/100 from every two hours to every four hours is given hypodermatically. If under the use of the larger doses of these drugs the tension still remains high, we depend on the use of veratrum viride rather than venesection.

The preparation used has been Squibb's fluid extract of veratrum and the dose employed has scarcely ever exceeded five minims. Our rule is to give five minims hypodermatically and watch the effect. As the frequency is usually reduced with the tension, it is our custom to be largely guided in repetition of the dose and in the size of the dose, by the frequency of the pulse, although the reduction in the tension is the object desired.

If at the expiration of from one to two hours the pulse has not been reduced in frequency to 100 or below, and the tension correspondingly reduced, a second hypodermic injection of veratrum one to three minims is given. The tension of the pulse is often controlled, if not kept low by the continued use of the nitroglycerine, by repeated doses of veratrum one to three minims every four hours.

4. To repeat the fourth principle previously stated: If the toxemia of the patient, as shown by the urine, blood pressure and general condition, does not markedly improve under the preceding principles of treatment, or if an eclamptic seizure occurs, the uterus should be emptied. At the Sloane Hospital some years ago, a series of patients was treated on the palliative plan, favoring elimination without emptying the uterus, but the mortality was so much greater than when the fetus and its toxins were eliminated from the uterus and the system, that for the past ten years the rule has been, given an eclamptic seizure, or a toxemia so severe as to strongly threaten eclampsia in spite of the treatment, proceed to empty the uterus.

In carrying out this rule, the fifth principle of treatment deserves marked emphasis and will be restated here. In all methods of

treatment, that should be avoided which will either reduce the resistance of the patient or seriously damage any of her organs.

This principle has an important bearing on the method of emptying the uterus. Having decided that the fetus should be removed from the uterus, the next questions are how and when? If the cervix is soft and dilatable and the patient has had one or more convulsions, our own preference is manual dilation and delivery, usually by version.

If on the other hand the cervix is long and rigid, we believe that the patient is better off, even if delivered several hours later, to have her cervix softened and dilated by the preliminary use of the elastic bag or bags, rather than to be delivered by an immediate accouchement force, which leaves her in marked shock and with cervix deeply lacerated, perhaps to the vaginal junction. Our observation leads us to believe that pronounced shock and deep lacerations lessen both the resistance of the patient and her chances of recovery. During the preliminary softening and dilation of the cervix, it is our custom to employ the methods already referred to for favoring elimination and lowering blood pressure.

In the cases with long rigid cervix, which do not readily dilate under the use of the elastic bag, the so-called vaginal Cæsarean section has a distinct and valuable field of usefulness. In a restricted class of these cases, future experience may prove the abdominal Cæsarean section to be the operation of choice.

DYSTOCIA.

The time at my disposal is too short to enable me to discuss in detail the ordinary methods of dealing with dystocia, viz: the forceps operation, version and the induction of premature labor. Suffice it to say that the most striking characteristics of the expert obstetrician are that by careful study of the fetal head, the pelvic canal and the relation between these two, he is able to safely and successfully deliver his patient in all ordinary circumstances by means of these non-cutting obstetric operations, without resort to the cutting operations which we will now consider.

Probably no branch of obstetrics has shown such marked advance as has obstetric surgery, especially the cutting operations for dealing with dystocia.

With pubiotomy my experience has been so limited as compared with that of my friend, Prof. Williams of Baltimore, that I do not feel competent to discuss it, but will simply state that in spite of his brilliant results with the operation, it has never appealed to me as an operation likely to have a wide field of usefulness.

With the operation of abdominal Cæsarean section, the speaker's

experience has been sufficiently extensive to be of some value, and this experience he desires to lay before you. He realizes in the light of riper experience that in a few cases, on account of the long hours and even days of previous labor with ruptured membranes he committed an error of judgment in exposing the patient to greater risk than would now be considered justifiable; still hindsight is easier than foresight, and while claiming no infallibility of judgment, he does claim that in his series of cases by no other operation, save possibly pubiotomy in a few, could a living child have been delivered, as in all save those with a positive indication for Cæsarean section, a thorough test of labor was allowed and in a few even the tentative use of the forceps.

It has been my privilege to personally perform at the Sloane Hospital, 107 Cæsarean sections, with the following indications:—Contracted pelvis, 84; fibro myomata, 7 (3 myometomies. 5 hysterectomies); ventral fixation, 6; vaginal fixation, 1; dermoid cyst, 3 (1 unilateral. 2 bilateral); ovarian cyst adenoma, 1; congenital displaced kidneys, (4 times in same patient); carcinoma of cervix, 1.

In these 107 cases there were 92 Sanger Cæsarean sections, and 15 hysterectomies.

In addition there were 10 Sanger Cæsarean sections in which the speaker assisted his assistants, and in which the speaker was responsible for the operation.

MATERNAL MORTALITY.

In the 107 personal cases there were 9 deaths, or 8.41 per cent. If the assistants' cases are included, in the 117 cases there were 9 deaths, or 7.69 per cent.

CAUSES OF DEATH.

Extensive carcinoma of cervix, mother in last stages, child macerated, death from shock within 24 hours, 1; pulmonary embolus, 4th day and 30th day, 2; intestinal obstruction on 5th day, autopsy showing no infection, 1; toxemia with degeneration of liver, death within 24 hours, 1; postpartum hemorrhage, death in three hours, 1; sepsis, death on 4th day, 17th day and 30th day, 3.

Excluding six deaths which occurred in women infected prior to operation, there were three deaths in a series of 101 cases, a mortality of 2.97 per cent., or if the assistants' cases are included, 3 in 111, or 2.70 per cent. These 3 deaths were as follows:—1 from embolus, 1 from intestinal obstruction, 1 from postpartum hemorrhage.

PERIOD OF RUPTURED MEMBRANES.

In 33 cases of the series the membranes had been ruptured for 8 hours or longer. In one they had been ruptured 5 days. In another

3 days. Both recovering. In 12 cases the membranes had been ruptured 24 hours or longer.

DAYS OF TEMPERATURE ABOVE 100.6°

The average, including 1 patient who recovered after 42 days of fever, and another who died after 20 days of fever, was 4.7 days.

There were 20 cases in which the temperature never reached 100.6°.

There were 52 cases in which the temperature was not above 100.6° longer than 2 days.

TIME OF DELIVERY.

In the series of 107 cases the average time of delivery was 37.30 seconds. Longest delivery 2½ minutes, the first of the list completed by hysterectomy for carcinoma.

Shortest delivery, 9 seconds. 28 were delivered in 20 seconds or less.

TIME OF COMPLETED OPERATION.

In the series of 107 cases including 15 hysterectomies, the average was 30 minutes and 39 seconds.

The longest operation was 1 completed by hysterectomy consuming 62 minutes.

The shortest Sanger Cæsarean occupied nineteen minutes in its completion.

The shortest Cæsarean section completed by hysterectomy consumed 33 minutes.

There were 46 Sanger Cæsarean sections which consumed not more than 30 minutes in the completion of the operation.

TECHNIQUE.

In the first 4 cases of the series the uterus was lifted out of the abdomen prior to the uterine incision. In the remaining 103 cases, a short abdominal incision with incision of the uterus in situ has been employed. While some operators prefer a short incision wholly above the umbilicus, my own preference is for a short incision the center of which lies opposite the umbilicus. My reasons for preferring this incision to one located wholly above the umbilicus, are as follows:

1. With this lower incision the uterus is less likely to slip away from the abdominal wound as the child is extracted. Cleanliness of the abdominal cavity is secured by keeping the uterus in close apposition to the abdominal wound.

2. If the Cæsarean section is to be completed with a hysterectomy it is more easily performed through the lower incision.

If, on account of previous infection of the uterine cavity, infection of the uterine wall should occur, a readier exit for pus through the abdominal wound, and easier through and through drainage are secured in the lower incision than in the higher. Whether the incision is made wholly above the umbilicus, or with its center opposite the umbilicus, the uterus at the end of a week is to be found below the abdominal incision so that permanent adhesion of the uterus to the abdominal cicatrix is not to be feared.

During my early work, the abdominal incision was carried to the left of the umbilicus, but during the last two years, on account of the usual rotation of the uterus from left to right forward and the tendency of the uterine incision to approximate the left uterine cornu, I have made it a rule to carry the incision to the right of the umbilicus.

As to the length of the incision in the abdominal wall and the uterus, it should be just long enough to admit of the delivery of the fetal head and the incision in the uterus should avoid the thin lower uterine segment.

The uterine cicatrix is often almost invisible at a subsequent Cæsarean section. The abdominal incision when sutured is usually not over ten cm. in length, and the resulting cicatrix is often not over five cm.

Several questions of technique present themselves.

After making the abdominal incision, shall the uterus be walled off by abdominal pads before it is incised? My own experience leads me to answer this in the negative. Although I have tried this walling off process a few times, I have abandoned it as unnecessary and less satisfactory in protection of the peritoneum than to have my first assistant keep the uterus firmly pressed against the abdominal wall from the first stroke of the knife till, following the delivery of the child, the uterus is lifted out of the abdomen.

HOW SHALL UTERINE BLEEDING BE CONTROLLED?

In my early operations it was thought necessary to have an assistant firmly hold each broad ligament, thus compressing the ovarian and uterine arteries.

This method has long been abandoned in favor of stimulation of the uterine contraction by gentle manipulation of the fundus with the hand, the pouring over the uterus of hot saline solution and the hypodermatic injection of aseptic ergot. Recently there has been a tendency to substitute pituitary extract for ergot. Every Cesarean section operator becomes impressed with the fact that uteri which show a tendency to relax and bleed when held outside the abdomen, contract well and cease bleeding when sutured and replaced within the

abdominal cavity. Hence too much time should not be spent in endeavoring to make the uterus contract outside of the abdomen, but either the suturing should be pushed and the organ replaced, or if the tendency to relax is too great, the uterus should be replaced and sutured in situ.

SHALL GAUZE BE LEFT IN THE UTERUS WITH END LEADING INTO VAGINA, FOR THE PURPOSE OF FAVORING UTERINE CONTRACTION AND DRAINAGE?

In the earlier cases of the series this was thought to be desirable, but I soon began to abandon it and in my last fifty cases it has been used only twice.

METHOD AND MATERIAL OF SUTURE.

In the first four cases of my series, the uterine incision was closed with silk, but in all subsequent operations with catgut.

The abdominal wall in the first six cases was closed with silk-worm gut supplementing catgut, but in the subsequent one hundred and one cases, catgut has been the only suture material in the abdominal as well as in the uterine wall.

The uterus is sutured with three tiers of continuous suture.

One approximating the middle muscular layer.

One passing through peritoneal coat and outer half of muscle wall, and one closing the peritoneum over the previous sutures.

The abdominal wall is sutured with three, sometimes four tiers of continuous catgut suture.

1. The peritoneum is closed with plain catgut.
2. The fascia is approximated with chromicized catgut.
3. The fat, if very abundant, with plain catgut.
4. The skin with a subcuticular suture of plain catgut.

Before leaving the subject of Cæsarean section, permit me to answer a question which is not infrequently asked. What is the advantage of a quick operation in the performance of a Cæsarean section? Why is the nineteen minute completed Cæsarean section better than one consuming sixty-two minutes?

All surgeons realize that any operation in which careful technique is sacrificed to time, is faulty in the extreme. However, in a Cæsarean section a careful technique coupled with a short time is preferable to a careful technique coupled with a long time for these reasons:

From the first cut in the uterus until the uterine incision is closed, and the uterus replaced in the abdominal cavity, the woman is losing blood from the uterine sinuses. The loss of blood means lessened resistance to infection and a lower convalescence. Hence my belief

that a nineteen minute Cæsarean section is better than one consuming sixty-two minutes.

The operation of Cæsarean section is an easy one. With careful technique, the mortality is low, yet after a fair experience with the operation my conviction is firm that in a woman's first labor, save where the indications are positive, the obstetrician should be very careful in deciding that a Cæsarean section is indicated.

Nature is sometimes more capable of dealing with the problem of dystocia than we suppose, and it is only fair that in doubtful first labors she should be given a chance and the wife, to say nothing of the husband, perhaps be saved the dread of an abdominal operation in case a subsequent pregnancy ensues.

On the other hand do not decide that Cæsarean section is contra-indicated just because the pelvimeter shows normal pelvic measurements. In two of my private cases, now rejoicing in healthy children, the pelvic measurements were above normal yet an impassable dystocia resulted from an abnormal angle between the sacrum and the lumbar spine. The need for the Cæsarean section was only demonstrated by a thorough test labor.

The dangers of repeated Cæsarean sections in the same patient differ but little from that of the original, provided the operation in subsequent pregnancies is performed promptly. On the other hand, to allow a woman who has had a previous Cæsarean section to remain long in a subsequent labor exposes her to the risk of a thinned uterine cicatrix and perhaps uterine rupture, as has been reported by several operators.

Gentlemen, the speaker has endeavored to lay before you the results of his experience in a fairly active professional life. He has told of his successes and has not concealed his failures. He has tried to point out both the Scilla and Charybdis of modern obstetrics and has plotted the course along which he has come with the hope that you, from considering this course, may not only avoid the rocks on either side, but may attain a greater success than he has achieved.

PHILIPPINE SERVICE.

The United States Civil Service Commission announces an open competitive examination for chief of the department of medicine, Philippine General Hospital for men only. From the register of eligibles resulting from this examination certification will be made to fill a vacancy in this position in Manila, Philippine Islands, at a salary of \$4,000 a year and vacancies as they may occur in positions requiring similar qualifications, unless it is found to be in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

OBSTETRICS.

BY DR. PHILIP W. DAVIS.

Mr. President and Members of the Maine Medical Association:

I am going to talk for a few minutes on obstetric needs in the State of Maine.

In this brief paper, I shall criticize our school for the poverty of clinical obstetric material and consequent poor clinical training obtained by its graduates, and suggest how this state of affairs might be improved.

I shall criticize the general practitioner who attempts to do obstetrics with his hands already full of other work; and I offer these criticisms, not in a captious spirit, but to draw your attention to certain changes which, in my opinion, would make for a higher standard of obstetric work in Maine, and benefit the profession and community as well.

Whatever I may say in regard to the relationship between the Medical School and Bowdoin College is said with due regard to the welfare of each institution. I am proud to be a graduate of Bowdoin College and the Department of Medicine at Bowdoin College. It is easy to criticize — harder to suggest the sane and proper remedy. I hope that you will see that I have tried honestly to do the latter.

Today, when we want good service of any kind, we employ the man who, in our opinion, is best fitted to give it; the man of widest experience; the specialist in his work, who can deliver the goods. Some of us may be of the opinion that specialization in medicine is overdone. I am convinced there is great need in our community of specialization in obstetrics. The work of the profession has come to be highly sub-divided, and the most fundamental division of this work is into internal medicine and surgery. Obstetrics, or mid-wifery, constitutes a third great department. In so far as obstetrics deals with normal labor, it asks no aid from medicine or surgery. The ordinary uncomplicated confinement is of no medical or surgical interest; but with difficult labor the problem at once becomes a surgical one.

Today our teachers have a high measure of obstetric truth. If we have learned anything it is that medicine has very little concern with child birth, and obstetrics is a surgical sub-division of the *ars medendi*. . . . Obstetrics is the modern, scientific development of the ancient art of midwifery. All of us can be midwives, and most of us have been such, but very few of us in this community are or ever will be obstetricians. To be a modern practitioner of the science of obstetrics, one must have had the very best surgical training coupled

with a large clinical obstetric experience. The man who practises in isolated localities will have to do this work, and he should see to it that his previous experience in midwifery combines a surgical training and an adequate amount of clinical work. The school which does not do so has no right to live and will in time be crossed off the list. Much of surgery and all of obstetric work is emergency work and cannot wait for skilled consultants or even for surreptitious reading to compensate for ignorance of the case. Whatever his knowledge of *materia medica* and practise, the country physician must be well grounded in minor surgery and obstetrics.

This community needs, and the profession should enthusiastically support a first-class medical school. Most of us are graduates of the Medical School of Maine, though we have no diploma to prove it. Your medical degree and mine was granted by Bowdoin College, and in it you will find no mention of the Medical School of Maine. This school has been a department of Bowdoin College since 1820, and is a corporate body, made such by the first legislature of the State. This fact that the school is a separate corporate body, has brought about such a curious state of affairs that it is hard to say whether we are graduates of a nameless medical school, or bastard sons of Bowdoin. Personally, I should be proud of any relationship with the college, bastard or legitimate. I am convinced, however, that the time has come when the relationship of the two institutions should be carefully investigated, and the obligations of the one to the other be made legally clear. That the college is beginning to awake to the fact that it has obligations to the school was made manifest when a committee was delegated to raise money to help it. The plan, embodied in a circular (issued January 10, 1911) was to raise \$140,000 to equip laboratories and build and maintain a dispensary. How far the committee have been successful I do not know.

It is all very well for the college to present the school with funds for these good purposes, but even this will not cure the real trouble, which is, that the Medical School of Maine has no standing except as a department of the college, a department to which the college is slow to recognize its obligations. I grant that the extent of these obligations is hard to determine. The Medical School of Maine is today nothing but a name—one to be mentioned with the reverence we pay to the departed. It has accomplished its work well and honorably. In fact, it has ceased to exist, except on paper. It should be abolished as a separate corporation. This action would leave its teachers precisely as they are today, professors of the Department of Bowdoin College; its graduates, alumni of Bowdoin College, with all the privileges of alumni, who, old and young, would then

rally to uphold the Department of Medicine of Bowdoin College. And in this new, old institution, the Medical Department of Bowdoin College, loyally supported by its alumni, one of the most important chairs is that of obstetrics. Proper management could secure plenty of clinical obstetric experience for the student.

To show approximately what obstetric material the school might offer, I call your attention to the vital statistics of the City Clerk of Portland for the year 1910. In that year there were 1,225 children born in this city. Five members of the medical faculty of the school delivered 208 of this number (17%, or about one-sixth of the total.) At 39 of these births, I officiated, and on looking over my records, I find that I employed a district nurse in over two-thirds of these cases. I am sure that I could have had a student present at one-half of my confinements that year. This means that my contribution to the clinical obstetric experience of the school might have been at least twenty cases. If the four other members of the faculty could have done the same, the school that year might have controlled one hundred cases of labor and given four cases apiece to a class of twenty-five men. (The class that year numbered twenty-one).

In the last few years men, graduates of the school, have come to me while interns in the Maine General Hospital, and said that they had never seen a case of labor, asking to be given the opportunity. This seems to me to be a fair statement of the supply of clinical obstetric material furnished to the student in this State. It appears to be still a matter of accident for our young physician to attend in this State a confinement controlled by the school before graduation.

The Professor of Obstetrics tells me, he has recently, May 1st, 1912, made arrangement by which this year men may attend several (ten or more cases) confinements at the Boston Lying-In Hospital, thus enlarging the clinical experience of the student and not adding very materially to his expense.

This arrangement does not help the situation here in Maine. The school is delegating a large part of the teaching of clinical obstetrics to an institution outside the State.

I am confident that the standard of obstetric practice in this State is low. As a matter of fact, there is no standard. The work is still in the hands of the busy general practitioner, who does the very poorest kind of obstetric work and whose general work suffers on account of the time and strength sacrificed to midwifery. We must educate specialists in obstetrics; and to accomplish this, we must not only offer more and perhaps better clinical teaching in the school, but we must establish a maternity hospital with a large free ward, whose management shall be in full sympathy with our school. In no other

way can we raise the standard of work, increase our skill as obstetricians and teach obstetrics or obstetric nursing.

(If we were educating clean male midwives, it would be worth something to the community. I believe we are not even doing that.)

I am tired of the argument that a man in general practice cannot afford not to do confinement work. Many affirm that this is the sole reason why they continue to accept such cases. The work is distasteful to them; they often do it poorly, and yet they are perfectly willing to continue to impose upon the public, taking money for services which are often worth less than nothing. These are the men who go about complaining of the small fees received for confinement work, as though \$10 to \$15 were not ample recompense to such men for the loss of a few hours' sleep. These are the men who plan to arrive at the scene of action in time, perhaps, to tie the cord, fill out the birth certificate, and collect the fee. I am tired of the man who hurries to a case of labor, encounters a *post partum* hemorrhage, and is obliged to send out in the night for ergot, his excuse being that his obstetric bag was not packed as he had just come in from another case. I am tired of the man who conducts normal labor, sitting in a room adjoining his patient, smoking cigarettes with the father, for which social diversion he collects fifty dollars. Lastly, I am tired of the man who says, "*Obstetriciam artem nec exercui nec exercere volo*," and yet when the cases pile up and he finds he cannot be in two places at once, he asks me to conduct one of these cases, saying that he will make the after calls and split the fee.

The profession as a whole has always sought to evade the conduct of labor, and there is an increasing number of physicians who regard it as an undignified and unnecessary task — one which could be safely handed over to any ignorant old woman. So it has come to pass that the work of the average practitioner in the conduct of labor is often inferior to that of the Sairey Gamps of fiction.

Perhaps the theory of midwifery today approaches perfection. You need not be told that its practice is far from perfect. It can not be doubted that it is vastly improved over that of any preceding age. Serious sepsis, in private practice, is said to be rare. Maternal and fetal mortality are probably low as compared with any former period; but the most sanguine will acknowledge that there is still great room for improvement.

In these days we have plenty of light; the dark spots have all been illumined by truth. When we practice what we preach, obstetrics and politics will alike be clean, safe and sane.

President — The paper of Dr. Davis is now before you for discussion.

Mitchell — So far as the relationship of Bowdoin College and the Maine Medical School appear to go there is more than a germ of truth in what Dr. Davis has said, still practically, the relationship is much closer than it would appear as you well know. The diplomas are granted by the college to be sure and all the officers are elected in the same way. Our finances are directed by the treasurer of the college, so that practically we are closely identified with the college. The doctor's paper is a fine one and I have enjoyed listening to it, but personally I feel a little disposed to modify somewhat the severe criticism which the reader has passed upon the general conduct of cases of labor. It was my privilege to try to fill the chair of obstetrics for the period of something more than twenty-five years, and I can say very honestly that I conscientiously tried to instruct the students to the best of my ability as to the management of cases of labor. I don't know if there are those present who will endorse what I say, but I think some of them have been in my classes, and I hope they will agree with me that I tried to teach them the best means and methods of caring for a case of labor and doing it in a clean and careful manner. Some of those men have been good enough to say to me that the instruction I tried to give them in the management of the various forms of hemorrhage in labor has since proved reliable, so that I do think Dr. Davis is a little wrong in some of his statements, for instance when he says that some of the men conduct these cases with absolute carelessness. I believe the great majority of men in this room — the vast majority — are gentlemen who conduct this work with reasonable cleanliness and care, and it does seem to me that to expect specialists to care for this work would be altogether impossible, especially when we come to think how many children are born each year throughout the country regions, where it would be utterly impossible that a specialist be called, and where the work must fall in to the hands of the country practitioner, and in most cases the work is done very well, cleanly, carefully and thoroughly. A specialist could not possibly get to these cases in season, and in many instances could not be afforded. I had occasion to speak with Dr. Cragin yesterday and asked him if they considered it necessary that the obstetrician be also a surgeon. He told me it would be impossible for that to be carried out to any very great extent in the country districts, but that they do their work carefully and thoroughly and then in cases of unusual complication, help can reasonably be obtained.

The point I wish to make is, and I wish to emphasize it, that from my own knowledge, the majority of the men present, and the men belonging to this association, conduct cases reasonably well. Those who conduct them in a conspicuously careless manner ought to be con-

During the first and second stages of pneumonia, digitalis is highly recommended by some authors claiming that it contracts the blood vessels and improves the pulmonary circulation thereby relieving the dyspnœa.

Cases of surgical shock are greatly relieved by digitalis combined with strychnia given hypodermatically.

In congenital heart disease with or without cyanosis, digitalis strengthens the heart and steadies the pulse. However it is not regarded as serviceable in infants or young children with nervous palpitation.

When the heart's action becomes feeble in typhoid, digitalis is frequently used, although it is claimed by some that it is liable to increase the diarrhœa and cause vomiting. High temperatures prevent digitalis from slowing the pulse as fever depresses the vagus centers in the medulla and probably the peripheral ends of the vagus.

Diastole is prolonged and the power of systole increased by digitalis so it is the remedy of choice in mitral insufficiency and stenosis, tricuspid stenosis, and tricuspid regurgitation with a dilated right ventricle. However in tricuspid regurgitation it should be administered carefully at first, or it may cause pulmonary apoplexy from increased pressure on the vessels. In aortic stenosis, the left ventricle is unable to completely empty itself, owing to the narrow aortic orifice. Digitalis, by increasing the ventricular contraction, allows the ventricle to empty itself as it should normally. In all of these valve lesions mentioned, do not give too large a dose at first or cumulative action may result with a premature arterial contraction throwing increased strain on the heart.

Cumulative action may also result from over stimulation of the heart when the drug has been used for some time causing syncope when the patient sits up in bed or suddenly assumes the erect posture. Cumulative action is liable to occur in ascites following tapping, especially if the drug has been given for some time. It is thought that the sudden withdrawal of pressure on the vascular trunks allows increased absorption of the drug with the juices of the tissues where it had remained inactive. Cumulative action is often preceded by a diminished secretion of urine so the physician should be on his guard and a diminished twenty-four hour amount of urine should be regarded as a danger signal, and the dose of the drug should be lessened or discontinued altogether.

The infusion of digitalis is most excellent in cases of renal dropsy on account of its diuretic action. Two digitalis compound pills are also extensively used by the profession in the treatment of this condition, one containing digitalis, calomel and squill, the other, contain-

ing digitalis, squill and potassium nitrate. My experience has led me to believe that while both are good, the latter combination is the more efficacious.

CONTRA INDICATIONS FOR DIGITALIS: — Digitalis is not borne well by patients in advanced years with a tendency to ætheroma. Given in this condition, it frequently upsets the cerebral circulation, causing headache, vertigo, nausea, vomiting and confusion of ideas. If the drug is continued, active mania may result but disappears in a few days if the drug is stopped.

In valve lesions when compensation is good, digitalis is not required and it is seldom needed if dropsy is absent and the patient is passing an abundance of urine. To give digitalis when compensation is good, is very much like whipping a willing horse. It seems almost needless to say that digitalis should not be given in apoplexy or in cases of post cerebral hemorrhage as it aggravates the former condition and is apt to cause a recurrence of hemorrhage in the latter condition.

Do not prescribe digitalis in advanced arterio-sclerosis as the increased arterial pressure is likely to result in cerebral hemorrhage and immediate death of the patient, or hopeless paralysis.

Digitalis should not be employed in obese patients with fatty degeneration of the heart as ruptured heart may result from the increased arterial tension on a heart that is already over-taxed.

Pericarditis is another contra indication to the use of digitalis. Given in this condition it causes a very full diastole or dilation of the ventricles, in a heart that is always cramped for space on account of the effusion present. However after tapping, if the heart becomes weak, digitalis is very useful combined with alcohol or caffeine.

Theoretically, digitalis should not be employed in aortic insufficiency for while it causes the heart to clear itself of regurgitant blood by increased systole, it prolongs the period of diastole thereby allowing so much more time for the blood to flow back into the ventricle. Nevertheless some cases of aortic regurgitation are apparently temporarily relieved by digitalis. However strophanthus is undoubtedly a better drug to use in this condition.

TO SUM UP IN BRIEF: — Do not give digitalis when compensation is good or in fatty heart, arterio-sclerosis, apoplexy, aortic insufficiency and pericarditis.

Digitalis does great service in renal cases associated with dropsy and in all valve lesions with the exception of aortic insufficiency, often permitting the patient to live a useful and fairly active life.

CASE REPORT.

DR. JOHN STURGIS, AUBURN, ME.

Read before the Maine Medical Association.

This is just the report of a case I have recently treated and as it was rather remarkable, I thought you might be interested in hearing of it.

Mr. and Mrs. Joseph M. Lancaster, Lisbon, Maine, found that their year and seven months old daughter, Hattie, had swallowed a dry bean on March 17th, 1912, at three o'clock P. M.

Hattie Lancaster was attended by Drs. Potter and Earle of Lisbon, who referred the case to the Central Maine General Hospital.

The next forenoon, the child was brought to the hospital, where the members of the nose and throat department made an examination and reported to me at 1.30 P. M., that the case did not belong in their department, as the bean was below the larynx.

I called a consultation of the medical and surgical staff. Because of the loss of all respiration in the right lung, and the labored respiration in the left, we decided that the bean was in the right bronchus.

The consultation recommended me to do as I wished: "If you do *not* operate the child will die, and if you *do*, it probably will." When I learned that the parents expected the child to die and were willing to leave it all to me, I decided to make a trial to remove the bean at 5 P. M., March 18th, 1912. The bean had been in the bronchus twenty-six hours.

I made a deep tracheotomy and through the tracheal opening used an electrical urethroscop as a bronchoscope, which was perhaps better than a regular bronchoscope for this work on a child.

With this improvised bronchoscope, I could see the bean and then I could not see it. I presume the efforts of the labored respiration changed the field of vision, and consequently I caught glimpses of the obstruction.

Upon my second attempt to grasp the bean with a forcep which was made for the removal of foreign bodies, I caught the bean and drew it from the right bronchus back into the trachea and to the opening, where my assistant, Dr. W. W. Bolster, held it by pressure below until I could take a new hold with another forcep, by means of which I removed the bean through the tracheal opening. The bean showed the expected results of having been in the bronchus twenty-six hours.

I made a closure of the wound with several layers of sutures. When I sent the child to the nursery, I advised the use of an ozonator

which was furnished me by Superintendent Gordon of the Lewiston & Auburn Electric Light Company. I believe the ozonator helped the child. It should be used with some care because it can overcharge the atmosphere with oxygen.

The child ran a bronchitis and my friend, Dr. E. S. Cummings, who was then on the medical service at the Central Maine General Hospital, treated it successfully.

I afterwards found a very small sinus existing; when the child cried the air whistled through it.

On April 1st, 1912, I made an attempt to close this sinus and was successful.

When I saw the child on June 7th, 1912, she had a wide scar, but otherwise was well — only being a "little croupy" during some of the rough weather.

Now in relation to the other matter: Why I questioned this muscular effect on high arched palates is I had a little experience which is unpleasant. My uncle was called to a case where a man who was working with a circular saw received a plank in the face, and it somehow broke the bones so that the whole upper jaw swung free. When he would try to talk or move his face, the whole upper part would move just as you have seen a set of false teeth that were not fitted properly. The whole upper part of the face would move in just that same manner and just as easily as some people can move their teeth about. We operated on him and removed such portions as it was necessary to do and then he was in such shape that I decided to let him alone for a while, but in time I gave that man ether, putting both fingers and a thumb under his front teeth — the teeth were not loosened, but it was a complete fracture of the jaw bone. By a good deal of manipulating, I could draw that upper jaw into position and hold it there, but it would only stay in the correct position when it was held there. If I lessened the traction with my thumb or with the combination which held it the muscles would take the upper jaw out of position immediately. It was impossible to get anything that would hold the upper jaw forward or the under jaw where it should be, and the man was developing malformation. If there is any way of holding these bones in place, I should be glad to get hold of it.

DR. STURTEVANT: I had a case last fall which was somewhat similar to this. I was called to see a man who had been run over by a cart which was loaded with two tons of crushed rock. The cart went over his head and fractured the superior maxilla, crushed many of the smaller bones and the teeth were all floating. The bones in the upper part of the face were all crushed and he was in a terrible condition.

After putting him under ether, I found things were in bad condition — badly crushed. I brought him to the Maine General Hospital, and there an attempt was made to set those bones, but they could not be held anywhere. We could not get respiration by any method through the nose, and at times he would seem to stop breathing altogether. He was put to bed and left there for a certain number of days and the muscles and bones all came into place so that now his face is as perfect as perfect can be, and the jaw works all right apparently.

I saw this man day before yesterday and he is in a great deal of trouble; his jaw, he says he can get along with all right because of the fact that it works sort of mechanically, but he cannot chew his food as he is unable to manipulate his front teeth. They are about an eighth of an inch apart. He gets an effect of respiration, but one night he came near dying. I was greatly surprised to think that while a man was under ether and then so far along, that there was a chance that he might die, but I didn't give up the attempt even when it appeared that death was approaching. I wanted to perform the operation fully because I had been told about the effect on the maxilla bone. I had seen a case before where one side was loosened but never before where both sides were loosened and in the condition of this case which I have described.

NOTICE.

DIABETES - MELLITUS.

I am undertaking an exhaustive research into the pathology, etiology and dieto-therapy of Diabetes-Mellitus. I am very anxious to hear from every physician in the United States who has a case under treatment or who has had any experience in the treatment of this malady. Van Noorden says "the best treatment for the diabetic is the *food* containing the *greatest* amount of *starch* which the patient can bear without harm." If any physician who reads this has similar experience or contrary, and would take the trouble to write me, I would esteem it a special privilege to hear from him, if only a postal card. Kindly address

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Editorial Comment.

Society Reports.

Following the custom of a year ago, a notice is sent to the Secretaries of the County Societies on the 15th of each month, calling their attention to the fact that the forms of the Journal will be closed by the 25th and that it will be necessary to have County News and Notes by that time. This has met with very good success in some counties, while in others, we have been unable to get any replies whatever. We believe the county news and notes should be the most interesting part of the work and have endeavored to get as complete reports as possible.

We sincerely hope that the new county editors will make special efforts along these lines, moreover, we should be glad of any suggestions from them in behalf of the county as to changes in the present method of running the Journal.

Medical Legislation.

During the past few years, the medical profession has shown great interest in matters pertaining to Medical Legislation, whereas during the past year, various important matters of this nature have been under discussion in every county society. The new acts relative to our insane hospitals providing

First, for eliminating the word insanity from the names of the hospitals, and

Secondly, the acts providing for emergency and voluntary commitments of the insane which are steps along lines of progress.

It is no longer necessary to designate a hospital which is devoting its resources to the care of our mental and nervous cases as an insane hospital, and the new acts provide that they shall be known as the Augusta State Hospital and Bangor State Hospital. When these become a law, it can readily be seen that the question of voluntary commitments is a feasible one. In other words, we can influence a friend or relative to sign a voluntary commitment paper to the Augusta State Hospital, where it would be impossible to get them to sign a commitment paper to the Maine Insane Hospital. We sincerely trust that these measures will receive the hearty support of the medical profession.

Some other bills to be presented at this session will be the act for creating a State Board of Charities which is in accordance with the similar work in other States, also the so-called Medical Expert Act, both of which measures received the endorsement of the county societies and finally of the State Association. The State Board of Registration, in their efforts to obtain a more satisfactory law than we now have at present, have entered a bill providing for the necessary changes. They have striven through the last few sessions of Legislature to enact laws which would benefit the State at large as well as the medical profession in that it will protect the inhabitants from a certain amount of quackery and at the same time continue to raise the standard of medical education.

Another act to be entered is "An Act for the Prevention of Obtaining Medical Charity by False Representation," which provides that any person seeking charitable, medical or surgical service will be guilty of misdemeanor and subject to a fine. This law is taken from the New York law and is similar to that which has been in operation in Pennsylvania for some years. Both States have found it a very useful law as doubtless will Maine when she has it in operation.

The above renumeration of various bills should be gone over carefully and if there is a question in anyone's mind regarding the value of any of the measures, a letter to the Legislative Committee of the county or to the Journal will find ready response. We firmly believe in all these measures and stand ready to work, not only for their enactment, but for their future success.

Fatalities from Breathing Nitric Acid.

Relative to the distressing circumstances that occurred in Portland recently when two firemen died, and several others were seriously ill from the effects of inhaling the gas given off from a broken container of nitric acid, it is interesting to note that other similar cases

have occurred in this country and Germany. The story of one such accident seems to be the duplicate of every other even to the most minute details, and all that can be learned from the past in reference to the present conditions is that the men who have inhaled this gas sufficiently to be made ill should be guarded most carefully for a rather great length of time in the future to prevent the occurrence of a relapse, and to promote the strengthening of the affected areas until they may again be in a normal condition. Previous experience has shown that exposure to cold, even after a considerable interval, may cause a repetition of the former severe symptoms, and that complete restoration of the affected mucous membranes necessitates a long convalescence. It is believed that the formation of the oxides of nitrogen, especially the tetraoxid, are the chief gases in changing the hæmoglobin of the blood, and that this condition, together with the broncho-pneumonia is the cause of death. This is an unusual condition to meet with, but the fact that in all the reported cases, the mortality has been practically twenty-five per cent makes it one which commands general attention from the doctor. The Journal is hoping in the near future to present a study of the Portland cases, together with those that have occurred in other cities.

International Abstracts of Surgery.

Surgery, Gynecology and Obstetrics.

This new Journal in its completeness will consist of the following:

1. A comprehensive index of surgery from all sources, arranged alphabetically under departments giving the author's name, subject of communication, and the Journal from which the article is abstracted.

2. An abstract of the surgical literature from all countries, prepared by the combined efforts of our French and German contemporaries and our own staff for Great Britain and America. This will appear under departments and will include abstracts and reviews of (a) original articles, (b) monographs, (c) books, and (d) clinics.

This publication will be issued as a supplement to Surgery, Gynecology and Obstetrics and will more than double the present volume of this Journal; it will be complete in itself and will be known as the International Abstract of Surgery.

Medico-Legal Matters.

***An Act for the Prevention of Obtaining Medical Charity by False Representation.**

STATE OF MAINE.

In the Year of Our Lord One Thousand Nine Hundred Thirteen.
Be it enacted by the People of the State of Maine as follows:

Any person who obtains medical or surgical treatment on false representations from any charitable institution organized under the laws of this State shall be guilty of a misdemeanor, and on conviction thereof shall be punished by a fine of not less than Ten Dollars and not more than Two Hundred and Fifty dollars.

(Imprisonment until fine be paid may be imposed. Applicants for medical charity shall be informed of the provisions of this act by the institutions to which they apply.)

***Expert Testimony.**

Copy of Statutes of Rhode Island, Chap. 292.

Sec. 18. "Any justice of the supreme court, may in any cause, civil or criminal, on motion of any party therein, at any time before the trial thereof, appoint one or more disinterested skilled persons, whether they be residents or non-residents, to serve as expert witnesses therein; Provided that the reasonable fees of such experts according to the character of the service to be performed, as fixed by such justice, shall be paid by the party moving for such appointment, to the clerk of the court at such time as the justice shall prescribe and the amount so paid shall form a part of the costs in the case. In criminal cases in the discretion of the court, on request of the defendant, expert witnesses may be furnished for the defendant at the expense of the State, on such terms and conditions as may be prescribed by the court.

Sec. 19. Such experts being duly sworn before a justice or clerk of the court to make a fruitful and impartial examination into the matters and things committed to them, and true report thereon to make according to the best of their knowledge, belief and understanding, shall thereon proceed to view and examine such persons, matters and things, to read and hear such evidence in such manner, times and places whether by attendance at the trial of such cause or otherwise, and to report their findings, views and opinions thereon, jointly or severally, orally or in writing, to the court when such cause shall

be pending before or at the trial thereof, in such manner as the justice appointing them, or any justice of the court sitting in the case, shall prescribe; and such report, if in writing, shall form a part of the record of the cause and shall be produced in evidence at the trial thereof, and such experts shall attend at such trial until excused by the court; provided that any party to the cause may call and examine or cross-examine, any such expert at the trial as to the matters, persons, things, views, findings and opinions contained, mentioned or referred to in any such report, without further summons."

***An Act to Provide for a State Board of Charities.**

(Text of act not available for present issue.)

*This act is to be submitted at the present session of Legislature.

Book Reviews.

A Treatise on Pellagra for the General Practitioner.

By Edward J. Wood, S. B., M. D., New York and London. D. Appleton & Co., 1912.

This work covers the history, etiology, complications, prognosis, and treatment of pellagra.

The chapter on the history and distribution will surprise many who do not realize the prevalence of the disease. The author states that in some sections of this country it is only less common than tuberculosis. It is therefore rather necessary that the general practitioner become better acquainted with pellagra.

The discussion of the etiology of the disease is exhaustive and fair and the author is noncommittal for he states that "the cause of pellagra is unknown."

The description of the cutaneous lesions is clear and the accompanying photographs are excellent.

A long chapter on the nervous and mental changes in pellagra covers the matter very accurately.

The prognosis according to the author is not so hopeless as many authorities despondently insist. Early recognition of the disease, change of climate, proper hygiene and treatment will often result in a complete cure.

The book is well printed and is a valuable addition to a well selected medical library.

G. A. P.

Diseases of the Hair.

By George T. Jackson, M. D., and Charles W. McMurty, M. D., Philadelphia and New York, Lea & Febiger, 1912.

This volume is the most complete treatise on the subject that we have seen. The matter is treated not only in a scientific manner but is very readable and is especially valuable to the general practitioner. The illustrations were evidently chosen to amplify the text and not to beautify the book.

The subject matter is discussed under five heads. 1. Anatomy, physiology, hygiene. 2. Diseases of the Hair. 3. Inflammatory diseases of the hair follicle. 4. Parasitic Diseases of the Hair. 5. Diseases of the hairy skin.

The first division is especially noteworthy in that it covers the subject so fully.

The chapters on ringworm and seborrhoea are very accurate and painstaking and represent the work of the best authorities up to the present time.

The selection of prescriptions is excellent and the introduction of the author's favorite treatment of the various diseases will aid the general practitioner in choosing his remedies.

The work of the publishers leaves little to be desired. The paper and type is excellent and the illustrations distinct.

G. A. P.

Progressive Medicine.

A quarterly digest of Advances, Discoveries and Improvements in the medical and surgical sciences. Lea & Febiger, Philadelphia and New York. Six dollars per annum.

The contents of Volume 14, No. 4 of Progressive Medicine treats of the diseases of the digestive tract and allied organs, kidneys, genito-urinary diseases; surgery of the extremities, shock, anaesthesia, etc., finally closing with a chapter on practical therapeutic referendum. It is a valuable reference book for any library.

The Practitioner's Visiting List.

Edited by Lea & Febiger of Philadelphia and New York. Price \$1.25 net.

Containing thirty-two pages of data which is valuable to the practitioner, including many needed references which can be quickly found, also blanks for recording all details of practice.

F. L. F.

Review of Current Literature.

Thymol-Alcohol as a Disinfectant of the Field of Operation.

By H. P. KUHN, A. B., M. D., KANSAS CITY, MISSOURI.

Consulting Oral Surgeon, Kansas City General Hospital; Surgeon to Swedish Hospital.

Acting upon the reports of A. Hoffman, the writer has tried a five per cent solution of thymol in a sixty per cent solution of alcohol in two hundred consecutive cases.

Two applications, one an hour and the other five minutes before the operation were made, excepting in emergency cases where one 5 minutes before the operation was made, care being taken to avoid an excess of the solution. It should not be used on the scrotum or the perineum, and the peritoneum should not be allowed to come in contact with the skin thus disinfected, as there would be liability of exciting inflammation. With these precautions, it has proved a most efficient method in obtaining an aseptic field of operation.

E. E. H., JR.

(Therapeutic Gazette, October 15, 1912.)

A Post Graduate Clinic at the Jefferson Hospital.

H. A. HARE, M. D., PHILADELPHIA.

In discussing a case of heart trouble, Hare claims that we must pay more attention to the condition of the heart muscle and pursue a different line of treatment in disease of the myocardium than in that of valvular disease. Of course, if the valvular lesion is marked and the myocardial disease slight, we should as heretofore, expect the best results from rest and the proper administration of digitalis or strophanthus. If, on the other hand, the heart muscle is chiefly involved, and especially if there are any symptoms of heart block, the drug that is most useful is atropine. This drug acts by depressing the peripheral ends of the vagi in the region of His' bundle and removes the functional obstruction, allowing the impulses to pass more readily from auricle to ventricle. Large doses of atropine are advised, as one one-thousands gr. every two or three hours. Hare states the large doses in the course of twenty-four hours produce less dryness of the tongue than smaller doses. Death from over-doses of atropine he

claims to be practically unknown. Together with atropine are advised rest and possibly a little tincture of strophanthus. Digitalis should not be given as it has some inhibitory effect on the passages of impulses through His' bundle.

P. P. T.

(American Journal of Obstetrics, October, 1912.)

A Study of Two Hundred and Twelve Cases of Cancer of the Uterus with Special Reference to Early Diagnosis.

BY GEORGE KAMPERMAN, M. D., ANN ARBOR, MICHIGAN.

As this is a careful study of all the cases of cancer presenting themselves at the Gynecologic Clinic of the University of Michigan during the last ten years, the conclusions of the author are interesting as pointing to the incidence and possibility of cure of that disease.

Cancer holds fifth place as a cause of death in Michigan, and during the last five years, the death rate from that cause has increased fifteen per cent. Among gynecologic patients, one in every twenty-five has cancer of the uterus. In five-sixths of all the cases, the disease was primary in the cervix, and in one-sixth primary in the fundus. The age limit varied from twenty-eight to seventy-five years, the average being forty-eight. Carcinoma of the cervix occurred most frequently between thirty-five and fifty-five years of age; carcinoma of the fundus between forty-five and sixty-five. Patients with cancer of the cervix presented a history of a child-bearing in ninety-two per cent of all cases; among patients with cancer of the fundus, the percentage was seventy-two. Heredity had very little part in the development of the disease. The first symptom in seventy-three per cent of the cases was an increased menstrual or irregular intermenstrual discharge of blood; watery and foul discharge and pain practically always occurred at a later stage of the disease; cachexia occurred only in the advanced stages, and many of the women were healthy and robust looking. The radical abdominal operation offered the only cure for those having carcinoma of the cervix, but a few cases of carcinoma of the fundus were apparently cured by a less radical operation. Most of the patients died either from some terminal infection or from uremia.

The article closes with the old, yet ever important statement, that earlier diagnosis must be obtained in order to cope with the increasing death rate from this disease, and to do this the profession as well as the laity must be better educated. All women must be taught that the menopause means lessened flowing, and that any increase in flowing at this time may signify disease.

R. B. M.

(American Journal of Obstetrics, October, 1912.)

The Therapeutic Application of the Ductless Glands.

BY HOBART AMORY HARE, M. D., PHILADELPHIA.

The author believes that these glands can be used in three ways: viz., to produce a sudden, positive and positively demonstrable effect, to cause certain changes in physiological function which can be recognized only after the results of these changes have had time to develop, and lastly, that a considerable part of drug therapy depends upon the effect which these glands (in the body) exercise when under the influence of drugs.

The first glandular product considered is pituitrin, obtained from the posterior portion of the pituitary body, which, when injected into a vein or subcutaneously causes a rise of blood-pressure, similar to that produced by adrenalin but much more prolonged, due to its action upon the muscular coats of the blood-vessels. It is therefore useful in cases of shock where there is a fall of blood-pressure depending upon depression of the vasomotor center, which, in its depression, might fail to respond to a drug acting directly upon the center. Pituitrin also causes a marked increase in urinary flow, its constricting action being confined to the peripheral vessels; hence, it is efficient where partial or complete suppression follows labor or operative interference with the genito-urinary tract, and also by its stimulant effect upon the muscular coats of the bladder may relieve vesical atony and so render unnecessary the use of the catheter. Its direct effect upon the uterus is to constrict the vessels, to produce uterine contractions when pregnancy has reached its completion, and to diminish the possibility of or to control actual post-partum hemorrhage. Most German writers agree that it is the best ecboic agent, acting promptly (usually within ten minutes from time of injection), having a fairly long-continued effect, and having no injurious effect upon the child, its only action being to increase the strength of the fetal cardiac contractions.

Ovarian extract is also considered, but is dismissed with the remark that its good results were probably obtained because of the extract of corpus luteum present in some preparations. The corpus luteum of the pregnant sow is said to be more potent than any other; it has no action upon urinary secretion, but does act as a stimulant to the pregnant uterus. Hare has used it in cases presenting nervous and mental symptoms of the artificial menopause, and has succeeded in giving relief after failure with all other remedies.

R. B. M.

County News.

CUMBERLAND.

The annual meeting for the year 1912 was called to order with Dr. John Thompson, President, in the chair. There was an attendance of eighty-three, including nine invited guests. The records of the last meeting were read and approved.

The annual report of the Secretary was read, approved and ordered to be placed on file. The Treasurer's report for 1912 was not ready and it was voted that it be read at the next meeting.

The name of Dr. Albert K. Baldwin was reported favorable by the Board of Censors and he was unanimously elected to membership.

This being the annual meeting, the following officers were elected:

President — Dr. E. E. Holt, Portland.

Vice-President — Dr. J. L. Bennett, Bridgton.

Secretary — Dr. Philip P. Thompson, Portland.

Treasurer — Dr. Roland B. Moore.

Censor for three years — Dr. Alfred Mitchell, Jr.

Six Delegates to Maine Medical Association — Drs. F. Y. Gilbert, F. H. Jordan, A. H. Little, C. B. Sylvester, N. M. Marshall, E. E. Holt.

After the election of officers, Dr. John Thompson announced that Dr. Taylor of New York had suggested that the society have a meeting open to the public on the subject of cancer. Dr. Thompson spoke favorably of the idea and Dr. Gordon also thought we should encourage Dr. Taylor in this work.

Dr. Gehring made the suggestion that our meetings might be more interesting if we had some discussions and papers by local men.

Dr. Gilbert spoke advocating more frequent meetings of the county society and proposed the following amendment:

AMENDMENT TO CONSTITUTION.

MEETINGS.

Amend first sentence of Section 2, Chapter 2, which now reads — "A meeting shall be held at 8 P. M. on second Friday of December, February, April and October. Etc." so as to read —

"A meeting shall be held at 8 P. M., on the third Friday of each month, excepting June, July, August and September, etc."

P. P. THOMPSON, *Secretary*.

ANDROSCOGGIN.

The regular monthly meeting of the Androscoggin County Medical Association was held in the court room of the Lewiston City Building, January 7th.

Records of last meeting read and approved. The first paper, read by Dr. Joseph Scannell, set forth the advisability of educating the public in regard to the dangers of cancer as is already being done with regard to tuberculosis. The second paper read by Dr. R. A. Parker, entitled, "Therapeutic Action of Spring Waters," brought out in a clear and concise manner the mineral content of several of the best known springs, and discussed the various characteristics of waters which make them valuable, both as therapeutic agents and as table waters.

A very interesting case history was presented by Dr. Harold Garcelon. The papers were discussed by those present, and a side question raised by Dr. Anson A. Cobb, as to whether the mortality from appendicitis was not increasing was also discussed.

S. E. SAWYER, *Secretary*.

KENNEBEC.

January 18, 1913.

The annual meeting of the Kennebec County Association was held at the new Augusta House, December 26th, 1912, President Dr. D. B. Cragin in the chair. The following officers were elected for the ensuing year:

President — Dr. Sylvester J. Beach.

Vice-president — Dr. Wellington Johnson.

Treasurer — Dr. G. R. Campbell.

Secretary — Dr. H. W. Miller.

Censor — Dr. L. G. Bunker.

Delegates — Dr. T. E. Hardy, Dr. D. B. Cragin and Dr. R. H. Stubbs.

A unanimous vote of thanks was extended to Dr. Wellington Johnson for his work as Secretary and Treasurer for the many years past.

After the banquet the following programme was presented: The President's address by Dr. D. B. Cragin, "Surgical Treatment of the Thyroid Gland." "Spinal Diagnosis," by Dr. John Adams of Boston.

H. W. MILLER, *Secretary*.

AUGUSTA MEDICAL CLUB.

The regular meeting of the Augusta Medical Club was held at the Augusta House, Monday evening, January 13th, when Dr. O. C. S. Davies entertained the members with a banquet. President Thompson in the chair. Fifteen members were present. The paper for the evening was presented by Dr. G. R. Campbell, on "Complications of Influence." The paper was well received and evoked much discussion.

H. W. MILLER, *Secretary*.

OXFORD.

The 17th annual meeting of Oxford County Medical Society was held at Mechanic Falls, December 30th, 1912.

About two-thirds of the entire membership of the society was present and considered themselves especially favored in being permitted to listen to a paper on "Eugenics" by Dr. Frederic Henry Gerrish of Portland.

Prof. Gerrish's paper was thoroughly discussed by nearly all those present and a rising vote of thanks was extended to him by the society.

Dr. Ralph W. Bicknell of Canton was balloted on and received as a new member.

The Secretary's and Treasurer's reports were read, audited and accepted and the following officers were elected:

President — F. E. Wheeler of West Paris.

Vice President — R. R. Tibbetts of Bethel.

Secretary — D. M. Stewart of So. Paris.

Treasurer — A. L. Stanwood of Rumford.

Delegate to Maine Medical Association — F. W. Morse of Canton.

Censor for three years — H. R. Farris of Oxford.

A Committee of Public Health and Legislation will later be appointed by the President-elect.

Dr. J. J. Cobb of Berlin, N. H., who has been an active member of the society since its organization was placed on the honorary list.

Dr. Marsh, the State President, finding himself unable to be present, sent Dr. O'Connor of Biddeford, the Second Vice President, to represent the State Association.

Dr. O'Connor addressed the society briefly on topics of interest to the State and County Societies. A discussion of Medical Charities and Medical Defense Fund was postponed to the next meeting for want of time and information.

D. M. STEWART, *Secretary*.

PISCATAQUIS.

The annual meeting of the Piscataquis County Medical Society was held in the law library at Dover, on Thursday evening, January 16th. Dr. Frederic Henry Gerrish of Portland read a paper on "Eugenics."

The following officers were elected for the ensuing year:

President — N. H. Crosby of Milo.

Vice President — C. C. Hall, Jr., of Foxcroft.

Secretary — R. H. Marsh of Guilford.

Treasurer — E. D. Merrill of Foxcroft.

C. C. HALL, JR., *County Editor.*

YORK.

The 19th annual and 71st quarterly session of the York County Medical Society was held in Odd Fellows Hall, Biddeford, Thursday, January 9th. Dr. E. C. Cook of York Village presided. The records of the October meeting were read and approved.

Drs. L. H. Brown, No. Berwick; W. H. Kelly and J. N. L'Heureux, Sanford; L. W. Parady, Springvale; R. L. Maybury, Saco, were elected to membership. Two new applications for membership were referred to the Board of Censors.

The report by the Treasurer, Dr. C. F. Traynor, Biddeford, showed the treasury to be in a very good condition. The report was accepted.

An invitation was received from the Webber Hospital Association to hold the April meeting of the Y. C. M. S. at the Webber Hospital, in Biddeford, and at that time to accept the hospitality of the association at a lunch to be arranged by the Superintendent of the Hospital.

It was voted to accept this invitation.

On motion of Dr. M. H. Ferguson, Biddeford, Drs. L. E. Willard, Saco; A. L. Jones, Old Orchard; C. F. Traynor, Biddeford, were appointed a committee to arrange for a speaker to address a public meeting in Biddeford, in accordance with the plan as outlined in the Speakers' Bureau, established under the auspices of the Council on Health and Public Instruction of the A. M. A. The following were elected officers for the present year:

President — Dr. L. E. Willard, Saco.

Vice President — Dr. J. R. Gordon, Wells.

Secretary — Dr. A. L. Jones, Old Orchard.

Treasurer — Dr. C. F. Traynor, Biddeford.

Censor for three years — Dr. E. C. Cook, York Village.

In regard to the matter of medical legislation to come before the present session of the Maine Legislature, it was voted, on motion of Dr. J. M. O'Connor, Biddeford, that the York County Medical Society, as a unit of the Maine Medical Association, will endorse whatever action is necessary pertaining to medical legislation before the legislature.

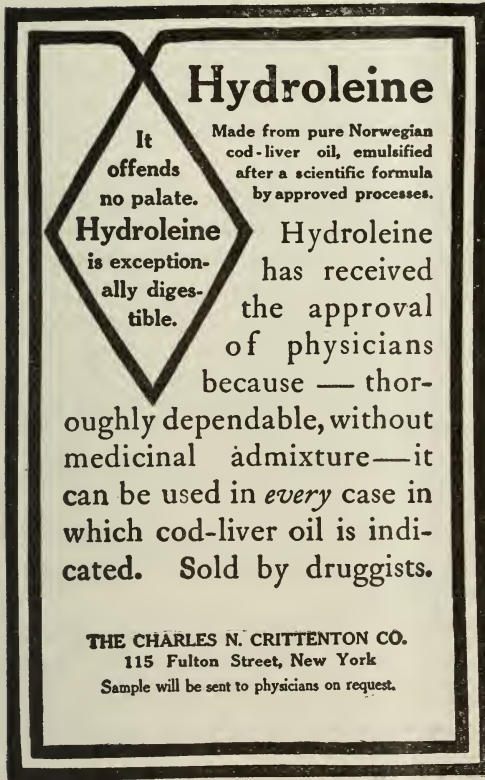
The literary program consisted of two addresses, one by Dr. Cook, the retiring president, and the other a paper, "Glaucoma," by Dr. A. H. Little of the Maine Eye and Ear Infirmary, Portland. These papers were especially entertaining, interesting and instructive. The speakers received close attention and generous applause. Dr. Little's paper was discussed by several, and a vote of thanks was extended to him.

The past year has been a successful one for this society. Five new members were added to the roll and five other applications were received and favorably reported on this year. Several who were suspended for non-payment of dues have been reinstated. There has been a better attendance than usual at the meetings for several years before, and the programs have evidently aroused considerable interest.

The Dutch Lunch that had been prepared under the auspices of Dr. O'Connor, proved to be a well enjoyed innovation in the festive part of the entertainment.

Those present: Drs. E. C. Cook, F. W. Smith, York Village; J. W. Gordon, Wells; W. W. Smith, Ogunquit; J. O. McCorison, L. H. Brown, No. Berwick; C. W. Blagdon, Sanford; L. W. Parady, Springvale; H. L. Prescott, Kennebunkport; C. E. Lander, S. B. Marshall, Alfred; P. H. Abbott, Goodwin's Mills; B. F. Wentworth, Scarboro; H. H. Purinton, Kennebunk; M. H. Ferguson, J. M. O'Connor, D. E. Dolloff, E. D. O'Neill, C. J. Emery, C. F. Traynor, C. F. Kendall, F. E. Small, G. C. Precourt, F. L. Davis, A. C. Maynard, Biddeford; H. A. Weymouth, J. D. Cochrane, J. D. Haley, C. W. Pillsbury, C. E. Thompson, L. L. Powell, L. E. Willard, R. L. Maybury, E. H. Minot, Saco; H. D. Grant, Bowdoinham; A. H. Little, Portland; J. A. Randall, A. L. Jones, Old Orchard.

ARTHUR L. JONES, *Secretary*.

PERSONAL NEWS AND NOTES.


Hydroleine

It offends no palate. **Hydroleine** is exceptionally digestible.

Made from pure Norwegian cod-liver oil, emulsified after a scientific formula by approved processes.

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THE CHARLES N. CRITTENTON CO.
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Dr. D. E. Dolloff of Biddeford gave an address in the Universalist Church in that city, Sunday evening, January 4th, on the subject, "The Health of the City." It was an able presentation of the problem and has been highly commended.

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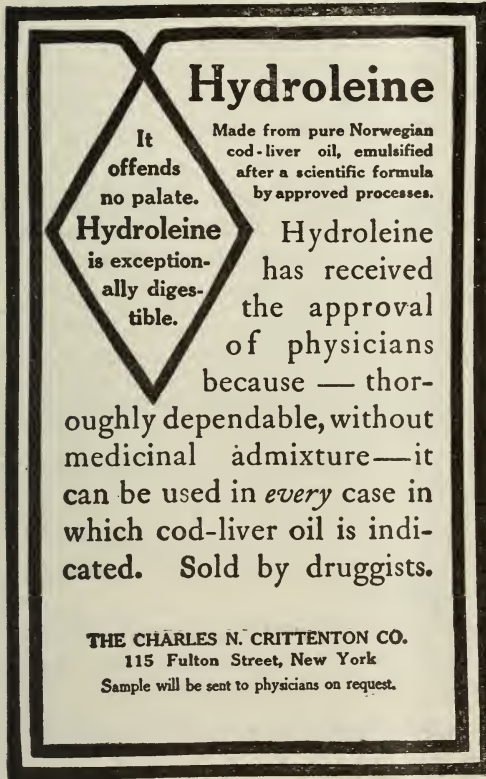
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Miss Stella Byrd Weymouth, the only child of Dr. and Mrs. Harry A. Weymouth of Saco, died Sunday, January 12th, at the home of her parents in Saco, after an illness of a little over a week, of pneumonia. She was born in Saco and her age was 19 years and 9 months. Miss Weymouth was a graduate of Thornton Academy in the class of 1910 and a young woman highly esteemed by all. The sincere sympathy of a host of friends is extended to Dr. Weymouth and family in their great bereavement.

Dr. B. F. Bradbury of Norway, who has been connected with the medical department of the National Guard for many years and was a major-surgeon in the Spanish war, has recently been appointed surgeon-general, with the rank of lieutenant-colonel.

Dr. F. W. Snell of Dennysville has moved to South Paris.

Dr. J. W. Crane of Princeton has moved to Dennysville.

Dr. C. C. Hall, Jr., of Foxcroft, has been appointed county editor from the Piscataquis County Medical Society.

Dr. and Mrs. Hiram Hunt of Greenville soon leave for Florida for the remainder of the winter.

Dr. C. C. Hall of Dover, who with his wife and daughter have been in California and the South for the last four months, is expected home the first of February.

Dr. J. A. Randall of Old Orchard started on January 22nd for Washington, D. C., where he expected to remain about two weeks, enjoying a vacation and visiting various places of interest.

Dr. J. R. Larochelle of Biddeford, expects to leave the middle of February for a two months' trip to Europe.

A hospital association has been organized recently in Sanford. The most prominent citizens, including the leading physicians, merchants and manufacturers are identified with the movement to establish a new hospital for the prosperous and thriving towns, Sanford, Springvale and vicinity.

The Committee of the York County Medical Society appointed at the annual meeting on January 9th, to arrange for a public meeting to be addressed by a physician provided by the Speakers Bureau. Council on Health and Public Instruction of the A. M. A. are attending to their duties, and it is probable that an important meeting will be held in Biddeford some time during the next few weeks.

Dr. D. W. Hayes of Brownville Junction was killed in a wreck on the Canadian Pacific Railroad, January 21st. Dr. Hayes was a valued member of the Piscataquis Society and his loss will be keenly felt.

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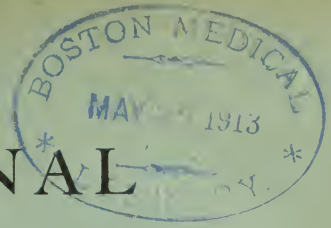


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MAR., 1913.

No. 8

PRESENT DAY METHOD OF ANAESTHESIA.

BY DR. WALTER M. BOOTHBY, OF BOSTON.

Mr. President and Gentlemen:—I only received the invitation of your President, Dr. Thompson, Tuesday night. The time to prepare a paper for this meeting has been so short that I hope you will pardon the somewhat fragmentary presentation of the subject.

New England can be justly proud of the work its men have done on the question of advancing surgical anesthesia. As you all know, David Wells of Hartford, Connecticut, made an attempt to demonstrate the value of nitrous oxide as a surgical anesthetic in 1844. In 1846, occurred the famous demonstration of complete ether anesthesia, by Morton at the Massachusetts General Hospital, on the invitation of Dr. John Collins Warren. Since that time the Boston surgeons have taken the lead in improving the methods of administration and increasing the safety thereof.

At the present time there is a general "revival" in the surgical world over the anesthetic question. The profession is beginning to realize that the large number of deaths due to the faulty administration of the anaesthetic must be eliminated.

What I shall attempt tonight is to give a true representation of the status of the research work on anesthesia as it stands today.

The question of anesthesia can be divided into three distinct problems, each of which deserves separate consideration. These are:

1. *The pharmacological problem:* The choice of the anesthetic and its dosage.

2. *The mechanical problem:* The aeration of the lungs.

3. *The physiological problem:* The behaviour of the respiratory center.

Our first problem, the consideration of the choice of an anesthetic, has created wide-spread interest throughout the surgical world. Only two drugs have entered into this discussion to any appreciable extent. These are ether and nitrous oxide. Chloroform in this country, or in this part of the country, at least, is practically a negligible quantity.

The use of nitrous oxide is dependent upon a constant, even supply of the gas being obtainable from steel cylinders in which the pressure is seven hundred pounds to the square inch. Likewise a steady flow of oxygen must be obtained from tanks in which the pressure may be as high as eighteen hundred pounds to the square inch. The relative proportion of each gas must be instantly adjustable to the needs of the case.

Furthermore, nitrous oxide will not in all cases produce sufficient relaxation for the efficient carrying out of the surgical procedures of the operator; accordingly, ether in varying amounts must be added as required for the particular case in hand. In order to estimate with any degree of accuracy the relative amounts of nitrous oxide and oxygen to be administered, the flow of these gases must be rendered visible by bubbling them through water.

Another essential point in a nitrous oxide apparatus is that every trace of air must be prevented from leaking in around the face-piece or mask. The slightest leak of air entirely prevents the production of anesthesia by nitrous oxide for this reason: Air contains 80% of nitrogen and only 20% of oxygen. In order to produce anesthesia, nitrous oxide must be present to an extent of from 85% to 90%. Oxygen to prevent cyanosis must never fall below 10%. Therefore, if 90% of nitrous oxide was being administered and 10% of air, we would be giving the patient only 2% of oxygen, which would of course be rapidly fatal. On the other hand, if we increased the air sufficiently to give 10% of oxygen, we would be also administering 40% of worthless nitrogen and only 50% of the anesthetic nitrous oxide.

The problem of obtaining an apparatus that would meet all these requirements was essential before a true study of the value of nitrous oxide anesthesia could be made. Accordingly, Dr. Cotton and myself, as you are probably aware, took this question up some year and a half ago, and we have evolved this apparatus which we believe effectively meets all the physical requirements for easily administering the proper proportions of nitrous oxide, oxygen and ether.

(Demonstration.)

As far as the manipulation of the apparatus is concerned, the administration is simple. The determination of the relative amounts

of nitrous oxide, of oxygen, of ether, and of carbon dioxide by re-breathing that should be administered is not so easily determined. In fact, it requires much study and experience, and these facts cannot be given in a paper.

There is, however, one point in the administration of nitrous oxide that I wish to emphasize as strongly as I know how: Never produce cyanosis! The proportion of oxygen inspired by the patient should never fall below the point at which the patient is pink. It is only safe when the patient is maintained at the border-line where you question to yourself whether or not cyanosis is present. When you are sure cyanosis is present, you are taking dangerous and unjustifiable chances, and you must, therefore, invariably increase your percentage of oxygen until your patient is again up to the border-line.

If you find it is impossible to relax the patient sufficiently for the surgical procedures to be carried out by the surgeon by means of simple nitrous oxide and oxygen administration, with a sufficient amount of the latter to prevent cyanosis, you should not attempt to obtain this relaxation by either of two methods which are recommended by some writers. That is, oxygen should not be excluded to the point of cyanosis, and no attempt should be made to use the dangerous method of increased intrathoracic pressure of the gases. This point of increased pressure as recommended mainly by Teter is based on the well-known experiments of Professor Paul Burt of Paris, about 1880.

The procedure of Burt consisted in enclosing the entire operating team and the patient in an air-tight chamber in which the air pressure was raised. The pressures of nitrous oxide and oxygen, as administered to the patient were correspondingly increased. The intrapulmonary pressure was thus compensated for by an equivalent increase in the pressure surrounding the patient in the air-tight chamber. Teter, on the other hand, increases the intrapulmonary pressure without any increase in the pressure of the atmosphere on the general surface of the patient's body.

You may remember that the right heart is filled by the blood flowing from the cavac into the auricle on account of the slightly lower pressure in the thorax than in the general venous system. The difference in pressure is very slight and in debilitated patients may not be over ten mm. pressure of mercury.

A brief consideration of this point will show you what a dangerous procedure it is to increase the intrapulmonary pressure, as thereby the blood may be prevented from entering the right auricle, and the patient die suddenly of cerebral anaemia.

Therefore, to obtain complete relaxation, we must add ether to the mixture inhaled by the patient in such a proportion that complete relaxation takes place. The amount of ether varies greatly in differ-

ent patients — some only taking a few whiffs, amounting to less than a dram — others requiring as high as two or three ounces during the course of an hour's operation, but in no case do they require as much ether as would be necessary if nitrous oxide was not the main anesthetic.

Is there any other way of avoiding the use of ether or decreasing the amount necessary when it is used?

I believe there is, and that is preliminary medication consisting of the subcutaneous injection of $1/8$ to $1/4$ grain morphia and $1/150$ to $1/120$ grain of atropin one-half hour before the operation.

Crile of Cleveland has written a great deal the past few years on the anoci-association principle of anesthesia, in which, although I cannot agree with him entirely in the theoretical working out of his hypothesis and the explanations thereof, yet I do believe in the advantages of his technique of injecting into the subcutaneous and muscular tissues novo-cocaine in the same manner as would be done for an operation under local anesthesia.

My hypothesis of the benefit of this procedure is that undoubtedly the reflexes from the handling of the skin, muscle and parietal peritoneum of this region are prevented from exciting the cerebral centers, and therefore a less deep stage of anesthesia is necessary. I think the benefits thereby accrued are due to the lessened amount of anesthetic, and not necessarily to lessened fatigue of the nerve cells themselves by a prevention of the reception of these irritating stimuli from the region of operation.

Nitrous oxide anesthesia appears to me to be the most desirable when it is administered by one who thoroughly understands the problem, and is willing to put time and effort into the mastery of it.

In order to get the best result for the patient, the whole problem of anesthesia must not be thrown upon the administrator. The operator himself must take an interest in the endeavors of the anesthetist to carry the patient with the least amount of anesthetic possible. Therefore, when the surgeon needs or expects to need absolute relaxation, he should warn the anesthetist some two minutes beforehand, in order that the anesthesia can be sufficiently deepened by the addition of the proper amount of ether. As soon as the need of this complete relaxation is past, he should again notify the anesthetist, so that the further administration of ether may be avoided.

As nitrous oxide anesthesia is light and the state of complete anesthesia is not widely divided from that of semi-anesthesia, the surgeon must not be unduly annoyed by the occasional occurrence of the symptoms of impending vomiting, which may or may not culminate in actual vomiting, but must wait one or two minutes until the anesthetist

has opportunity to deepen the anesthesia. The surgeon must also be willing to take the additional five minutes required to use the subcutaneous and intramuscular injection of nova-cocaine.

Whether or not it is advisable to also use quinine and ureahydrochloride subcutaneously in the wound just before closing it, as is done by Crile, in order to prevent pain in the wound after the operation, is a debatable point. It probably does no harm and may prevent some discomfort. As yet I have not entirely made up my mind as to the extent of its value.

The patient after a properly conducted nitrous oxide-ether anesthesia is far more comfortable than after an expert ether anesthesia, and of course not comparable with a "routine ether." A few patients have absolutely no nausea or vomiting. The majority have a slight amount of vomiting just as they are recovering consciousness, and occasionally during the next ten hours; unlike the vomiting of ether, it is accompanied by practically no distress or nausea. Water is always given the patient to drink as soon as asked for.

The usual reply to your question, "Do you feel sick to your stomach?" is not that given by the ordinary ether patient, which you all know so well; but is: "Oh, no, but my wound hurts so!" Usually the patients recover consciousness on the table while the bandage or dressing is being applied, and by the time they are returned to the ward and put in bed, can carry on a conversation rationally. On the next morning's visit they give the appearance of a three day old ether patient, and are bright and cheerful.

The most satisfactory patients for gas oxygen are those who have previously had ether. There is no question in the mind of such patients about the difference in their feelings after the gas oxygen and after their previous ether experience. If a third operation is necessary, you cannot persuade a patient who has undergone both methods to revert to the straight ether.

As to the relative dangers of nitrous oxide-oxygen-ether anesthesia as compared with that of straight ether, our knowledge at present is too limited for us to give any dogmatic conclusions. We must realize that until a very large number of cases have occurred in which this form of anesthesia has been used, we must suspend judgment. In my own hands, I have had no deaths nor even the appearance of any alarming symptoms. Conditions *have* arisen, however, which, I feel, *might* have led a less experienced person into a dangerous position. I cannot help but feel that if this method should become unduly popular, and turned over to inexperienced hands, under such conditions, it would not prove as safe as ordinary ether. In the hands of one thoroughly understanding nitrous oxide anesthesia and conversant

with the physiology of respiration, I feel that the method is as safe as that of ordinary ether anesthesia, and it has the further advantage of probably causing less frequently serious postoperative complications.

The mechanical problem of anesthesia — aside from that of apparatus — is one of maintaining a free current of air through the mouth, pharynx and larynx.

In 1909, Meltzer and Auer described what has since become by perfected technique an absolutely ideal method of artificial respiration. It is equally as efficient when the patient is not breathing — that is, not moving his chest walls — as when he breathes, or the thoracic walls are performing their normal functions. It is therefore of immense practical value, and, in fact, essential in intrathoracic operations. It is also of great value in operations about the head, neck and mouth, in which the close proximity of the anesthetist to the field of operation is a disadvantage. It is especially indicated in those intracranial operations in which there is likelihood of irritation of the respiratory center, thereby causing temporary cessation of the respiratory movements.

It is a comparatively simple method, and is safe if any one is willing to take the trouble of mastering the fundamental principles on which it is based. These principles are a continuous insufflation of air by means of a catheter introduced through the mouth into the trachea; the return of air takes place between the catheter and the tracheal wall. After the introduction of the catheter, there is only one possible danger to be avoided, and that is closure of the vocal chords around the catheter so tightly as to prevent a reflux of the air. Such a condition, or spasm of the chords, occurs when the patient is too lightly anesthetized, and is a sure indication of the necessity for more ether.

In order to prevent serious complications of emphysema, which may be so severe as to result in immediate death, due to the closure of the glottis around the catheter while the inflow stream of air is still continued under pressure, there must be a safety valve arranged on the ingoing stream near the patient. This safety valve must be absolutely effective, and must never allow a pressure inside of the lungs to exceed 6 mm. of mercury.

The simplest way of making a safety valve is to put a T-tube into the current; the free end of this T-tube dipping 6 Mm. into mercury contained in a bottle.

The introduction of the tube after the trick is once learned is very simple. The essential point is that the patient must be very deeply anesthetized by the administration of ether by the cone before

any attempt is made to introduce the tube. The patient should be so deep that there should be no spasm of the jaw and no reflex irritation when the finger is inserted into the oropharynx.

If the patient is thus anesthetized, it is a comparatively simple matter, by the use of this introducer devised by Dr. Cotton and myself, to intube the trachea by introducing the forefinger of the left hand until it touches the tip of the epiglottis and inserting the instrument in the median line, curving right back on the posterior wall of the tongue.

As you see by the diagram here, you must just get back of the epiglottis and then pull the handle of the instrument forward, or upwards as the patient lies on the table, with the handle standing at right angles to the mouth of the patient. An assistant then feeds the catheter in and you slowly withdraw the instrument from the mouth, preventing the catheter from slipping out by holding it against the tongue with the forefinger which is in the oropharynx.

Neither mouth gag nor tongue forceps are necessary, and the introduction after the technique is learned should not take over ten or fifteen seconds.

The intratracheal anesthesia, however, should not be attempted by one who is not willing to thoroughly study the subject, and who does not expect to carry through a sufficiently large number of cases in which the method is actually indicated, so that it will be worth his while to completely understand it.

Aside from the intratracheal there are two methods whereby the outflow and inflow of the respired air can be greatly facilitated, and which are suitable for use by any man possessing ordinary knowledge of anesthetics. They are the Crile nasal tubes, and the Davis-Sewall mouth gag.

The simpler of these two methods is the use of one or two nasal tubes, as recommended by Crile. They are about six inches long, consisting of ordinary rubber tubing, guarded at the external end by a safety pin, and fenestrated at the internal end. They are to be thickly coated on the outside with vaseline, and are to be introduced through the nares into the oropharynx in any case of embarrassed respiration. Those who are unfamiliar with this little trick will be surprised at the instantaneous improvement in the patient with whom they are having difficulty in keeping the jaw and tongue forward.

For oral operations in which intratracheal anesthesia is not to be used for any reason, the Davis-Sewall mouth gag and tongue retractor is most serviceable. By means of any vaporizing apparatus, for example, that devised by W. F. L. Richardson, air with ether vapor can be delivered by means of this tube directly into the oropharynx. The gag holds the mouth widely open and the retractor pulls the

tongue forward and leaves a free passage for the air. If a vaporizing apparatus is not present, the whole mouth gag can be covered with about fifteen or twenty layers of gauze and the ether administered thereon by the drop method. Although I am a firm believer in the advantages of intracheal anesthesia in intrathoracic operations, I do not believe in its universal use in other cases: except, of course, with a frank avowal of using such cases for the purpose of developing the technique of the anesthetist. The use of either the nasal tube or the Davis-Sewall mouth gag is far better for the usual run of cases. Both these methods can be used by any one with reasonable experience in anesthesia to their own personal satisfaction and with great benefit to the patient.

Our third, or physiological problem, is an entirely new subject for the surgeon and the anesthetist; it concerns the behavior of the respiratory center.

In 1905, Haldane and Priestley, of Oxford University, proved that the regulation of the rate of alveolar ventilation in breathing depends under normal conditions on the carbon dioxide pressure in the respiratory center.

Let me attempt to explain this fundamental law a little more fully. As you know, CO_2 is one of the products formed by the combustion of tissues in the body, and it is eliminated therefrom by means of the blood conveying it to the lungs and by the lungs to the external air. Being an excreted product, it has always been looked upon as valueless and as having no proper function of its own. The physiologists have recently shown us that a constant amount of CO_2 is maintained in the body under all normal conditions. In other words, there is approximately 45%, by volume, in the body at all times; and it has been shown that any increase or any decrease in this amount produces disagreeable and dangerous symptoms. The regulation of this amount is entirely maintained by the rate and depth of respiration. "*The respiratory center is so exquisitely sensitive to any rise or fall in the alveolar CO_2 pressure, that a rise of .2% of an atmosphere in alveolar CO_2 pressure is sufficient to double the amount of alveolar ventilation during rest.*" In other words, a very slight rise in the carbon dioxide pressure in the body will double the volume of respiration. Conversely, a slight decrease in the carbon dioxide percentage in the body will decrease the respiration and even abolish it.

Dr. ————— has very kindly consented to perform for you a respiration experiment. He will breathe as deeply and fast as he can for two minutes. I wish you to note the result at the end of this

two minute period. He does not know what to expect and we will wait and see what happens.

(Demonstration.)

I have brought down some volumetric tracings to show you the typical reaction after forced breathing. You will see here the violent respiration maintained for two minutes. Here a period of $2\frac{1}{2}$ minutes or thereabouts, in which the subject did not breathe at all. Here you find a shallow respiration rapidly increasing in depth, followed by a gradual decrease and return of the apnoea. You will see several such periods here, or a typical Cheyne-Stokes' respiration.

Now what has happened? The violent respiration here has washed out from the body a large amount of its reserve CO_2 and has removed thereby the stimulus to respiration. During this period of apnoea, that is, cessation of respiration, the subject has gradually re-accumulated his CO_2 until at this point it has just reached the threshold value at which respiration is stimulated. This, however, is not the whole story, because during this period there were formed in the body other substances that were respiration proceeding normally would be completely oxidized. These substances when formed under a condition of lack of oxygen help the carbon dioxide to stimulate respiration. These two or three breaths cause these abnormal substances to be completely oxidized in the lungs, and the withdrawal of their stimulating effect on the respiratory center. Therefore respiration again ceases until the combined efforts of carbon dioxide and more newly formed products of incomplete combustion again stimulate the respiratory center. This process keeps up until normal respiration is re-established by the entire re-accumulation of the CO_2 which had been washed out during the forced breathing.

Wherein does this experiment illustrate the induction of ether anesthesia? You are conversant with the preliminary ether excitement at which time the patient is breathing rapidly and deeply. This period, depending on the skill of the anesthetist, may be more or less violent, and more or less prolonged. Suddenly there occurs a change in the behavior of the patient; the respiration becomes shallow or entirely absent. There is frequently a period one or two minutes long in which the patient does not breathe, at the end of which time he may show symptoms of beginning cyanosis. If this period is not unduly prolonged, we are not alarmed. We have come to regard it as a natural phenomenon and we have learned to expect that immediately subsequent thereto the patient will recommence normal respiration and be in a state of surgical anesthesia. Occasionally, however, this period is prolonged until deep cyanosis occurs, sufficient to cause the anesthetist and attendant surgeon considerable worry. Oc-

casional death occurs. It is for the prevention of these deaths that I have called your attention to this respiration experiment tonight, in order to explain the reason for this long period of cessation of respiration, and to suggest means of overcoming the same. Death, if it occurs, is due primarily to a deficiency in the oxygen supply to the central nervous system on account of the cessation of respiration. Oxygen-want in itself is no stimulant to respiration and when the carbon dioxide has been abnormally reduced, the patient may die simply from the failure of any desire to respire. What should we do in cases like this?

We should, of course, perform artificial respiration very slowly, not rapidly. Our aim is to give the patient sufficient oxygen to prevent death during the time that the body is reaccumulating its carbon dioxide. If pure O^2 is available it is preferable to the use of air. We should not perform artificial respiration so rapidly that we continually wash out the CO^2 as fast as it is formed. We must allow for the reaccumulation of the CO^2 . Theoretically, the administration of a mixture of O^2 containing about 4% carbon dioxide would be highly desirable. Such administration, however, at the time of the emergency would be as a rule impracticable, the nearest approach being to use your own expired air; in other words, blowing into the mouth of the patient, not a particularly agreeable procedure.

It can easily be seen that a less violent increase in the respiration continued over long periods might produce dangerous symptoms. In fact, such is the case, and our attention has been called to the effect on the circulatory system of decrease of the carbon dioxide of the body by Yandell Henderson of Yale. He has shown on animals that a condition clinically identical to that of surgical shock can be produced by a long continued period of moderately increased respiration, but as yet his work is unconfirmed from a clinical standpoint.

CHRONIC LEAD POISONING FROM DRINKING WATER.

BY DR. D. M. STEWART, SOUTH PARIS.

Read before the Maine Medical Association, June, 1913.

Mr. President and Members of the Maine Medical Association:

Before beginning my paper, I wish to acknowledge my indebtedness to Dr. Gehring for his help in microscopical work, to Dr. Colby for clinical work, and to Dr. Young of the State Board of Health for his interest in sending me much valuable literature.

When the term lead poisoning or plumbism is heard, it brings to the mind of most physicians the picture of a blue line on the gums, a paralyzed wrist or abdominal colic. This degree of lead poisoning is too old, too well understood and too simple to be discussed here with much value.

I believe great harm may result from taking minute quantities of lead for a long time, and yet none of these cardinal symptoms manifest themselves.

It is my desire to convince you that enough trouble often follows the use of water delivered through lead pipes to make the subject worthy of your consideration. During the past two years, I have had about twenty-five samples of water which had run through a lead pipe analyzed, and not one was free from lead. Natural waters rarely contain any trace of lead and probably never in an amount injurious to health. According to a report of the Massachusetts State Board of Health, practically no water can stand in a lead or lead-lined pipe over night, without taking up some lead. The only exception to this statement is that highly alkaline waters will unite with the lead forming an insoluble coating which prevents further action. Such waters, however, are rarely used for drinking purposes. Since lead can serve no purpose in the bodily economy but is a cumulative poison, why should any one continue for years to drink water that has had a chance to be contaminated? And yet several thousand people in the State of Maine are drinking just such water.

It is true that in most of these cases the amount of lead is usually small, but the spring floods or the droughts of summer may change the quality of the water so that it will take up a dangerous amount. In Norwood, Massachusetts, the public water supply was analyzed to determine the advisability of using lead pipes and the amount of lead dissolved was so small that they were used. Later, in 1904, the increase in population and drought rendered the supply so low that the quality of the water was changed and a large amount of lead was taken up and many serious cases of poisoning followed. Experiments have shown that water containing a large amount of carbonic acid or oxygen will act most rapidly on lead, and that high temperature and pressure increase this action. Also that water coming from the ground, i. e., springs or wells, contains more carbonic acid than surface water. Therefore we find more lead poisoning in the rural districts and smaller towns which are not supplied with lakes and especially in hilly regions where water can easily be run from a side hill into the house. If the water takes up a large amount of lead, the usual symptoms of acute poisoning, such as blue line on the gums, abdominal colic and wrist drop may appear and the case is at once diagnosed. But

if the amount of lead is small, perhaps none of these symptoms will manifest themselves, and yet I believe lead poisoning may exist. It is the chronic form, presenting indefinite, changeable, uncertain symptoms with which I wish to deal.

So far as I can learn, special attention in this country was first called to this particular kind of lead poisoning in 1898, by the Massachusetts Board of Health. At that time, more than a hundred cases occurred in the city of Lowell, several of which terminated fatally before the cause was discovered and removed. Lead service pipes were in use quite extensively in their water system and all these cases were readily traced to the water, as the source of contamination.

A large number of these cases were carefully studied and the results recorded. From these investigations and from the cases I have had under my care, and from those reported to me through the kindness of other physicians, I wish to draw several conclusions.

1. That only a small number of those exposed to this danger are effected, showing that immunity is not the exception but the rule.

2. That it is not safe for persons especially susceptible to the effect of lead to take continuously even the slightest amount. .05 of a grain in 100,000 parts has sometimes been considered the smallest amount of lead that could cause trouble, but the continuous use of water containing less than one-half of this amount has been followed by wrist drop, while lead has been detected in the urine where less than one-quarter of this amount occurred in the drinking water.

3. That examination of the blood usually furnishes no help toward the diagnosis of these chronic forms, neither does analysis of the excreta always reveal lead. In one case, examination of the urine showed no trace of lead, but after ten grains of K. I. had been given three times a day for ten days, a second analysis revealed a large amount. This shows that lead even when present in the system is not always being excreted by the kidneys. Boos of Massachusetts has found that lead is more largely expelled by the bowels than by the kidneys. From the histories of about a hundred cases, it would seem that women are more susceptible than men or children, but possibly this is due to their being more closely confined to the house and drinking less water away from home. The length of time required to produce symptoms depends upon the amount of lead contained in the water and the susceptibility of the individual. No immunity is established by beginning with a small amount. A large quantity such as .50 in 100,000 parts has often caused marked symptoms in less than a month. Since the effect is cumulative, why should not one-half the amount produce the same results in two months, or one-twelfth the amount in a year?

In a general way this theory seems to be borne out by clinical experience.

The pathology and pathological histology of this trouble has unfortunately been little written about. I find recorded where a girl of seventeen died after drinking water containing lead for three months and analysis of the kidneys, liver and spleen showed the presence of lead, also the oesophagus, stomach and duodenum but in a smaller amount. It is known, however, that the blue line on the gums is caused by a deposit of sulphide of lead in the tissues. Why is it not reasonable to suppose that a similar deposit in other places is the causative factor. Blue line on the gums is almost always accompanied by spongineos and often by pyorrhœa. An unhealthy and inflamed condition of the mouth usually co-exists.

The ingestion of this foreign substance must act as an irritant and tend to reduce the normal resistance of the tissues rendering them an easy prey for the invasion of germs.

Why should not deposits in other organs cause similar conditions, and why should not lead be deposited in any organ, especially in those containing mucus membranes like the mouth?

Should we not suspect at least that lead is sometimes deposited in the kidneys, urethra, bladder or vagina, and if deposited in the kidneys and infection gains a foothold on the impaired area would not inflammation and suppuration with the usual symptoms of fever, pain and swelling follow? Or if lead should be deposited in the mucosa of the bowels producing red and inflamed areas such as we know are caused in the mouth, might not an infection follow resembling a low grade of typhoid? I shall later cite cases that cause me to make these suggestions.

The prognosis of this stage of lead poisoning is good. Recovery is often rapid when the cause is removed. Those cases which have been of the longest standing are the slowest to recover even though the symptoms are no more pronounced or no more numerous. If the trouble has progressed to the stage of paralysis, the prognosis is poor for complete recovery.

The early symptoms of lead poisoning are many and varied. Some of which are constipation, indigestion, slight pallor or a waxy or jaundiced appearance of the skin, insomnia, general pains through any part of the body, especially the arms or legs, which is often thought to be rheumatism, tremor, nervousness, a peculiar, restless feeling tending toward melancholia, kidney trouble, dysuria, especially in the female, disordered menstruation and sometimes miscarriage. Cabot in his differential diagnosis attaches considerable importance to a slow pulse and the finding of stippled red blood cells. Neither of these have been

prominent symptoms in the cases I have seen. At one time, I feared my interest in the subject had caused me to attribute symptoms to lead poisoning which properly belonged to other causes. Lest you may feel the same, I want to quote from Dr. Obermuller concerning the effects of lead in public water supplies. This is a translation from a German Medical Journal dated October 1st, 1895, and concerns the troubles following the ingestion of lead.

(Dr. Obermuller in Hygienische Rundschau, Oct. 1, 1895.)

LEAD POISONING BY PUBLIC WATER SUPPLIES.

1. A state of physical and mental depression, well described as a state of listless languor, a condition of body and mind where everything seems a trouble, where life seems oppressed by an unaccountable burden, and where the only thing to do is to sit down in a state of misery and let things take their course.

2. Anemia, with its attendant evils. This, says Dr. Oliver, is the one physical sign above all others which indicates that the system is becoming impregnated with lead.

3. Blue line on the gums. This is present in a number of cases that show no other sign, and on the other hand, may be absent in severe cases.

4. Colic. A common and early symptom.

5. Digestive troubles, e. g., pain, vomiting, nausea, constipation or diarrhœa.

6. Various irregularities of the functions of the reproductive organs of women, and frequently causes abortion to an extent sufficient to effect the birth-rate.

7. An injurious effect on the male reproductive organs.

8. As a consequence of these, the deaths of newly born children.

9. A whole train of severe nervous diseases; e. g. —

(a) Ill-defined pains, and cramp-like sensations in the limbs and pains in the joints.

(b) Weakness and wasting of the muscles, leading on to paralysis.

10. Blindness.

11. Diseases of the liver.

12. Diseases of the kidneys, which often are chronic and cause death after a lingering period of misery and suffering years after the original cause is forgotten: And following on from these, the heart and blood vessels are affected.

13. Gout, according to some, is frequently caused by lead poisoning; others say that it is only a co-incidence and not the result of plumbism. Dr. H. agrees with the latter.

In regard to the limit of safety, Dr. Whitelegge states that no water should be used for drinking which contains more than one part per million, and *any trace, however minute*, indicates danger. (Public Health, London, 1895.)

The diagnosis in the earliest stages is difficult and often impossible. I believe the detection of lead in the urine is usually the first positive diagnostic symptom. Stippled red blood cells will be found early where pallor is a prominent symptom. Either of these findings should be positive proof of the presence of lead in the system.

The treatment is largely symptomatic. If a diagnosis is made early, removal of the cause is all that is required.

K. I. without doubt helps to eliminate lead from the tissues and cathartics and diuretics aid in removing it from the body before it is reabsorbed. Hot baths and sweating may be of benefit.

I wish to read as briefly as possible the histories of several cases which I believe to have been effected by the use of water which contained lead.

I. Mrs. C., aged thirty, has been drinking water for the past five years which contains .02 of a grain of lead in 100,000 parts. Within the past two years, she has aborted three times at about two and one-half months. She denies having done anything to bring about these abortions and my knowledge of the circumstances causes me to believe she told the truth.

Previous to this she has been five times pregnant and has five healthy children living. She has had no other troubles during the past four years which has required the services of a physician.

II. Eva, aged seventeen, had pain in the abdomen which after consultation we diagnosed as appendicitis, and her appendix was removed at a neighboring hospital. The appendix was somewhat inflamed, but not so badly as we expected to find it. The abdominal pain continued and she got nervous and rather anæmic, showed blue lines on the gums and examination of the drinking water showed .15 of a grain of lead in 100,000 parts. She is improving gradually with a change of water, small doses of K. I. and out of door exercise.

III. Mrs. A. H. D., aged sixty-eight, was taken suddenly ill in the night, two weeks ago, with severe pain in the region of the sciatic nerve. She has felt poorly for several years and last winter I found that a small piece of lead pipe was in use, and had the water analyzed, finding .09 of a grain in 100,000 parts. The lead pipe was changed and she was given K. I. The cause of this recent attack of sciatica seemed doubtful and I sent her urine to Prof. Evans of Augusta for analysis, and he reported lead to be present in more than a trace. Sore mouth, general malaise and sciatica are the only symptoms this woman has

ever had, but I believe these were caused by drinking water which had run through a lead pipe.

IV. Female, twenty-four. Always been well and came from a healthy family. After living in house one year had pains in arms and legs which I diagnosed as rheumatism, but could not relieve. Also complained of painful urination at times which medicine did not help. Became pregnant and her dysuria increased and she began to be troubled with constipation. Gave birth to a small anemic looking child which she nursed. She grew nervous and had severe headaches and abdominal colic, also sore mouth and spongy gums.

Child did not grow and was weaned at four months on account of sore mouth and malnutrition. The mother became worse, with pain in right side, cystitis, vaginitis and extreme dysuria and was put in bed. After remaining in bed for a week without improvement, the right kidney became enlarged, painful and extremely sensitive and the temperature rose to 105. Within a few days she began to pass a large amount of pus in the urine and was somewhat relieved. The pus was examined for T. B. by a pathologist and none could be found. She was put on a milk diet and gradually gained. Pus continued in the urine and it was again examined and T. B. was reported as probably present. She was improving slowly and no change was made in her treatment. Got able to sit up some but could not walk.

Meanwhile the child became extremely constipated and irritable with a very sallow waxy skin, and was diagnosed as tubercular.

The husband had slight abdominal pains and was nervous.

A boy three years old was apparently well.

At this time the man secured a better position in another State and soon moved his family there. I told him that T. B. had been found in his wife's urine and urged that she be placed at once under the care of some physician.

I saw her and the child a year later and they both looked healthy. She told me she had consulted a physician but once during the year and felt perfectly well. Lead poisoning was not suspected.

At that time the water supply of his house had about one hundred feet of lead pipe. Seventy-five feet of this pipe was changed before the water was analyzed. The remaining twenty-five feet showed .09 grains in 100,000 parts of water.

V. During the past winter, I was called to see a woman sixty-seven years old who was suffering from a severe attack of Cardiac asthma. She was extremely nervous and shaky. Arteries badly sclerosed, trace of albumen in the urine, blood pressure 180. Said she slept very little, worried a great deal and was mentally uncomfortable. Her mental symptoms increased and she died three months later of insanity.

She had a son thirty-three years old who told me that he had wrist drop at the age of twenty-eight in the right wrist, following a bowel trouble which was diagnosed as typhoid. He was nervous, pale, constipated and had severe headaches. He improved enough to go away to visit relatives and while away got nearly well.

Returned home and all his troubles began again. The water was analyzed and no lead found. His condition grew serious and the extensor muscles of the other wrist became paralyzed. The water was again analyzed and .24 of a grain of lead in 100,000 parts was reported. He was treated for lead poisoning and constantly improved.

I first saw him one year after he had begun treatment and five years after the beginning of the symptoms just mentioned. His wrist muscles were still very weak, his skin was pale and a blue line could be distinctly seen on the gums.

This young man and his mother gave me the following history of his father's illness and death. That he drank a great deal of water and seldom drank anything else. That he had severe headaches and was badly constipated, and went two weeks at one time without a movement, although a physician was making daily calls and trying various methods of clearing out the bowels. That he was very nervous, cried a great deal, and was unable to control his feelings. That he had paralysis of the muscles of his wrist exactly as his son had later, and that he grew gradually worse with these symptoms till his death occurred at the age of fifty-nine.

VI. In July, 1911, Mrs. W. E. P., aged thirty-nine came to me with the following history. Had been in poor health for the past six years with headache, constipation and indigestion. These troubles have gradually increased. Began to sleep poorly and have peculiar sensations in her head about a year ago. Insomnia has grown worse and weakness of the legs has been noticed for the past three months. (Three years ago, I attended this woman for several weeks on account of a bowel trouble, which in consultation with another physician was diagnosed as a low grade of typhoid. No red spots appeared on the abdomen and the Widal reaction was reported as negative.)

General appearance anaemic, skin sallow, poor and emaciated, foul, sweetish odor to breath, gums spongy and red with a faint blue line on lower jaw. Pyorrhœa with teeth decayed along border of gums. A great deal of tenderness over stomach and bowels. Blood pressure 120. Sixty feet of lead pipe was installed ten years ago through which water has since been pumped into the house. Analysis of this water showed .22 of lead in 100,000 parts.

The husband of this patient began to get uneasy in his mind and complained of abdominal pains which he himself diagnosed as appen-

ditis. The water supply was changed and the woman was given eight grains of K. I. three times a day and a small dose of magnesia sulphate every morning was added to her other laxatives. She has constantly improved and now requires one-third the amount of cathartics. She sleeps well, her color is fairly good, she has gained ten pounds in weight and says her head feels all right.

VII. Mrs. V. A. W., aged thirty-four, came to me in May, 1911, with the following history. Began to feel ill in November, 1910. Been living in same place and drinking same water for past eight years. as husband and two children, aged thirteen and nine. Been rather nervous for one and a half years, with insomnia and palpitation. Previous to that time had been very robust. In November, 1910, was having nervous chills, spongy gums, red patches in mouth, no appetite, (abhorrence of food) sour stomach with large amount of gas in stomach and bowels, weakness of left arm and left leg, no paralysis, complained of peculiar sensation in stomach and head, felt melancholy and was afraid she was going to be crazy, cried a good deal, constipated, pronounced insomnia, no headache, peculiar creepy feeling on skin of legs, dysuria. General appearance was worried and sickly, skin dark, breath foul, pupils normal, reflexes exaggerated, stomach very tender on pressure, heart normal in sound but rapid, blood pressure, 130.

Water comes from a spring through three hundred feet of lead pipe and analysis showed .25 of lead in 100,000 parts. The lead pipe was removed and all medicine was taken away from her except cathartics. Thirteen months later, she told me that she slept well, had a good appetite and no abdominal pain and was as well as she ever was except for a little indigestion and constipation and occasionally slight dysuria.

VIII. V. A. W., husband of Mrs. V. A. W., aged thirty-seven. Was exceedingly nervous, irritable and melancholy; worried about expenses and work. Left his old place and went to work in shoe-shop. Had crying spells and threatened to commit suicide. One year later: All nervous symptoms have disappeared. In good health except for a mild form of indigestion.

The two children were apparently well during this time.

President:— The paper will first be discussed by Dr. Wheeler of West Paris, or, Dr. Wheeler not being present, the paper is open for a general discussion. Anybody who has anything to say may feel free to say it.

Dr. Robinson:— I am not accustomed to talking before this Association and if I make any errors I hope you will all overlook them and pardon me. I am greatly interested in this subject as in the town

of North Yarmouth— four or five miles distant from here we have been troubled with very many cases which were hard to understand and sort of indefinite in the extreme. I was unable to find the cause of the trouble and could not decide whether it was from chronic rheumatism or other conditions. I could not seem to decide just what caused the trouble. During my investigation of the subject, I sent twenty-four samples of the water to Doctor Young of the State Board of Health and he wrote me asking if there had been any complaint made of the water in that locality. There seems to be a large subterranean water supply under portions of the town, and part of them use this water for drinking purposes, they drink this water, and a large number of the people have the water go through a lead pipe that was put down there. I guess the most of them do not use that water any longer, but at that time they nearly all did. One family in particular at West Custago, you may have heard of it—the water comes up from a sort of boiling spring—and this family lived there close to a hill and their water came through this lead pipe to them. I had the water analyzed and found it contained .24 of lead in 100,000 parts of water, as has been spoken of in the South Paris water. In that family I had one case where there was a great deal of pain which has since developed other complications, one other particular rheumatic and definite pains through the kidneys, back and limbs, some of the other members of the family are nervous; it does not effect all the members of the family in the same way even in the same family and same source of drinking water. In this vicinity, there was one piece of lead pipe about two hundred feet in length that when they uncovered it, the water spurted right out through the pipe. The pipe in that instance had been entirely eaten up and I might go on and mention a number of other specific cases showing the deadly action of lead upon drinking water. But as I have already stated, I sent away twenty-four samples of the water to be analyzed and in twenty-one of them there was found to be different quantities of lead present, the amount apparently depending upon the time the water was confined in the pipe or was running through it. I think that as soon as we find some way of getting rid of all that lead pipe and its effects, that they will all be well people, for they are families that are naturally healthy and have no organic diseases.

President:— If there is nothing further to be said on the subject the paper goes back to Dr. Stewart for discussion.

Dr. Stewart:— I believe I have nothing further to add except that physicians meet with a great deal of resistance from property owners, it being difficult to convince them that any trouble can arise from this source. Also that this lead pipe has its effect on the stock

of farmers. I have seen one case of colic causing a horse's death which I believe was due to lead, and two heifers which came out of the barn in the spring with paralysis of the legs which I believe was due to the same cause, drinking water that ran through a lead pipe. I don't take quite so hopeful a view of the matter as my brother who discussed the paper in regard to the prognosis. I almost expect trouble to follow the arrest of these symptoms such as follows from syphilis and alcohol. Even after we get these difficulties conquered, there are evil consequences to overcome before we can get the effects out of the system, and it seems to me that we may have a good deal to attend to along this line before we have fully eradicated the evil with all its serious effects.

President:— Unless there is some objection this paper will be made a part of our record.

SMALLPOX—A FEW PERSONAL OBSERVATIONS.

E. T. FLINT OF FOXCROFT.

The history of smallpox which furnishes a very interesting chapter in medical literature, is to be found in nearly all of our standard text books on practice and is well worth reading by both the medical profession and the laity. In it we are told that the disease was first described by Galen in 200 A. D. with numerous valuable additions up to the ninth century, and from time to time thereafter. It was introduced into this country through Mexico by the Spaniards in 1521, since which time numerous epidemics of varying magnitude have been reported, and it is possible that the country has never been free from it since that date.

Constant care on the part of public health officials with knowledge gleaned from the costly experiences of past generations has so subdued the disease that it bids fair eventually to seek classification among the minor ailments, and so pass out as an active menace to human health.

The numerous epidemics in this State during the past seven years, and many sporadic cases, have furnished a basis for these few observations, but no opportunity has presented itself for observation in the larger centers where foreign types are numerous, brought in by sailors and travellers from all countries which would, of course, form a better foundation for a broad and accurate investigation.

These observations then are confined solely to the disease as we see it, and no attempt has been made to justify discrepancies between

it and the classics, or to investigate farther than would be interesting to the general practitioner.

The period of incubation averages thirteen days, but may vary a few days either way, depending presumably upon the resistance of the individual affected and the virility of the organisms which cause it.

The ordinary symptoms of onset are pain in the back and usually the lower extremities, and are described as being deep and about the bones. Headache is an immediate forerunner of fever which may or may not amount to 105, its intensity depending upon the type which is to follow.

In the mild cases usually encountered it will average 102° - 103° and the character of the pulse is in accordance with the severity of the fever.

Gastro-enteric disturbances may be present but are usually absent in mild cases except that the bowels are usually loose. Sore throat is almost invariably present in some degree, especially in cold weather, and is important in diagnosis although a late symptom. Chills may precede the fever, but are not of so constant occurrence as to offer any aid in diagnosis. The eruption comes first on the forehead at about the fourth day of the disease, may be sprinkled sparsely over the scalp and rapidly followed by an involvement of the integument of wrists, palms of hands and soles of feet, and so on to a general eruption over the body, or the eruption may be practically confined to forehead, wrists, palms and scattered rarely here and there over the trunk. The exposed surfaces are prone to show the worst eruption.

As the eruption progresses, the "split shot" feeling is noticeable, usually about the papulo-vesicular stage and with the beginning of pus formation in the vesicles the temperature, which usually goes down with the appearance of the initial rash, returns in a severe form but not invariably. There may be found eruptive spots in all stages while the general eruption is pustular, which is somewhat confusing in cases of disputed diagnosis. (Some spots appear to abort and do not follow the true course of macule, papule, vesicle and pustule.) Scars depend upon the depth of infection in the skin and can be controlled to a large degree by proper precaution. The eruption is usually found on the buccal surfaces, in the throat, inside the lids and in many instances on the cornea, where it takes the form of ulceration. All symptoms abate gradually with disappearance of the pustular fever, and the cycle may be completed inside twenty days.

The usual sequelæ are, in order of frequency, enteritis, albuminuria and conjunctivitis, the latter being more frequent in these observations owing to the fact of many cases being among lumber operatives where proper care of the eyes was not possible owing to

local conditions. The contagion, while undoubtedly active from the first, is far more so at and following the pustular stage and increases with desquamation.

Numerous cases have been observed in lumber camps where two unvaccinated men slept either side of another in the early stages of the disease, one or both contracting the disease and as frequently neither. No case was observed where an operative protected by a vaccination of seven years or less duration, was afflicted.

Symptomatic treatment of existing cases appears the most satisfactory, salts being freely used unless contra indicated by too free purgation or a delicate stomach, and carbolized vaseline covering the eruption. When possible, it has been my custom after the abatement of the fever to give daily baths of bichlorid solution followed by general inunction of carbolized vaseline which tends to limit the spread of infection and prevent deep inroads of the sores into the skin with subsequent scars. By the free use of carbolized vaseline the danger from contagion is reduced to a minimum, the exfoliating epidermis adhering to the body to be washed off with warm bichlorid solution and all excreta being emptied into vessels containing some strong germicide.

Vaccination stands alone after the individual and concerted attacks by organized societies for that purpose, as the great preventative treatment of the disease, and with the perfected methods of its preparation now in vogue, few if any, ill effects are ever encountered.

That in the early arm to arm vaccinations and even later, there was transmitted such diseases as syphilis, tuberculosis, anthrax and a host of other diseases there is no doubt, and upon the strength of statistics compiled from these results have the anti-vaccination societies been able to survive. Today a vaccination is practised with as much anti-septic precaution as any major operation, with a consequence that while its effects are lasting, its immediate discomfort is comparatively trivial. Physicians no longer resort to inoculating a patient at two points on the arm, as it is possible to get a satisfactory "take" with one inoculation if done properly, and experience demonstrates that the tissues will react to show within ten minutes whether or no a vaccination will take in most cases.

Immunity to a well done vaccination is a guarantee of immunity to small pox and vice versa. As to the time of protection a vaccination affords, if done properly with the patient's comfort in view, a vaccination will protect for seven years on an average, but will protect relatively longer with the severity of the symptoms it occasions. Observations show that a scar one-quarter of an inch square or smaller is sufficient for all practical purposes, although in the tremendous

inoculations of former days, immunity has been conferred covering a period of from twenty-five to forty years.

Vaccinations co-existent with the outburst of the disease appear to modify its severity and shorten all stages, those done during the disease have no apparent effect, and will not take unless the disease be very light and the inoculation very severe.

Vaccinations of syphilitics show no ill results, several upon patients with gonorrhœa appear to increase the discharge and inoculation upon tubercular patients healed slowly and were apt to react with a high temperature. Vaccinations upon several pregnant women from one to three months pregnant, and one eight months, were productive of no ill results but care was exercised to give mild inoculations.

An infant one month old was vaccinated with no attendant ill results beyond a slight elevation of temperature.

The left arm in right handed persons is the most satisfactory site for vaccinations and it should be done on the outside about four or five inches from the point of the shoulder. In the case of women and girls, who do not wish the unsightly scar in places which fashion decrees shall be exposed from time to time, the lower border of the popliteal space offers the best site, but vaccinations on the lower extremities, especially in women, are prone to result in swelling and œdema from their dependent position and to heal slowly.

In the first American edition of Hunter on the blood (1796) he records the fact that in 1780, he laid before the Royal Society an account of a woman who had smallpox during pregnancy, where the disease seemed to have been communicated to the foetus.

My own experience appears to show that it is possible for an immunity to be conferred in utero as in the only instance of this nature coming under my direct observation, the mother was confined during the vesicular stage of smallpox, and the child did not subsequently contract the disease. The child was repeatedly put to breast but owing to the disease, the flow of milk was not well established, and its feverish condition was so offensive that it was not possible to observe what if any, effect this would have upon the child's immunity.

Another instance worthy of mention was that of a quarantine attendant twenty-eight years of age who was immune from birth, his mother having died of smallpox at the time of his delivery. This man was also immune to vaccination as well as the disease, as repeated exposures well showed. He asserted that he did not have the disease at birth.

The particular part of the ordinary case is in handling the quarantine and under conditions in which we usually find these cases, this is not always an easy matter. In extensive epidemics where the dis-

ease has assumed a light form, owing to its passage through several generations of more or less vaccinated subjects, there is always strenuous objection to quarantine and its proper observation. The State laws provide a penalty for a quarantined person whether it be one afflicted with the disease or not, who escapes and so lays others open to infection, and it makes the offense the same to one going into a quarantined house and returning: it provides a penalty for defacing or ruining a quarantine card, but it does *not* provide any penalty for driving a nail above a card and hanging a coat or hat on the nail. This ingenious method of temporarily obliterating the stigma of being quarantined and allowing neighbors to call, has been the cause of much trouble to quarantine officers, and it will be readily seen how impossible it would be to ascertain the identity of the callers, trace them out and shut them up in instances where there was no guard or patrol except at two or three day intervals. In handling an isolated case in a small one or two roomed house or in a lumber camp, where in this State this disease has been most prevalent, the customary procedure has been to have a cap and robe kept in a fairly tight grip and well sprinkled with formaldehyde solution. Upon going into a house the robe and cap are donned, a few bichlorid tablets are left in a basin of water outside the door and upon coming out the cap and robe are removed, put in the grip and sprinkled for the next time and the face and hands washed with the prepared bichlorid solution.

In disinfecting, the forty per cent formaldehyde solution and permanent crystals have given the best results. To a thousand cubic feet of room space, a pint of the solution is placed in a wide mouthed receptacle and the potassium poured in. Pails of formaldehyde are placed in or contiguous to each room space of a thousand cubic feet, the rooms carefully made as air tight as possible and beginning from the most remote room from the exit, the disinfecter goes from pail to pail, pouring in seven and one-half ounces of permanganate to the pint of formaldehyde and closing doors between rooms. This is facilitated by weighing out the right amount of potassium and making a measure to be used in dipping up the right quantity, as there is much need of haste. The coarse crystals are the best. A four hour exposure in ordinary cases serves the purpose, but where there is need of haste, double the quantity of both materials may be used, and the time of exposure may be reduced as the disinfecting process depends upon a large volume of gas quickly generated, rather than upon a long exposure. Articles of clothing should be soaked in germicidal solutions and all other articles so disposed about the rooms as to allow free penetration of gas to all surfaces.

Formaldehyde vapor will kill plant life but will not, in ordinary cases, destroy flies or body lice. It will not injure most cooked foods

or vegetables. The room should always be as warm as possible to facilitate circulation of the gas, as cold will cause its condensation and render the most careful technique absolutely useless.

Where the house or camp is small, the change of clothing is placed in a tight barrel, well sprinkled with formaldehyde solution and sealed up for a few days, spread out to air, and after a bihclorid bath in some convenient place by the patient, donned and the patient liberated while the house is being fumigated. By this procedure, domestic routine is hardly inteferefed with.

Care should be exercised to air the bed clothing, else an iritis and laryngitis will ensue, the latter being sometimes of a very severe nature, and stimulating a common cold. Some of these cases have proven stubborn to treatment.

Burning sulphur fumes are a good disinfecter but difficult of managment, and as yet, not well enough perfected in technique to become generally used.

In closing, and to illustrate the manner in which the disease is spread, I will report a case, and submit illustrations which came under my observation several years ago in the northern part of this State while acting as a representative of the State Board of Health.

This man came by rail from Spring Hill, Nova Scotia to Portland, Maine, September 19th. With a companion, he boarded a freight to Waterville, remained in town an hour and a half, boarded another freight for Bangor, where the morning of the 20th they had breakfast at a restaurant and went by electrics to Old Town, visited a barber-shop, went to Indian Island, returned, picked up three other like characters, boarded a freight to Millinocket, had supper at a restaurant, began to be sick and break out, and slept in a wood-shed. The twenty-first he walked to Grindstone and went to a mill boarding house to eat, stayed all day and that night in a camp between Grindstone and Davidson, and the 22nd boarded a freight to Island Falls, walked with the other four to Oakfield, arrived there at night, and hired to pick potatoes, remained over night and to breakfast, sleeping in a barn, and the forenoon of the 23rd went to see a doctor and was shut up.

The case came under my observation that day and was as follows: Name, Joseph Moore, age 27, single, occupation, miner; well developed, strong, rugged, never vaccinated. Residence, Spring Hill, Nova Scotia.

First began to be sick about September 19th, noticing a dizziness accompanied by headache and malaise, which continued with increasing severity until September 22nd, when fever became high, followed by sore throat and great prostration. Spots appeared on forehead, rapidly

spreading to entire body, and headache and fever disappeared. Throat was very sore and patient was unable to swallow. Anorexia pronounced. There was severe pain in all the bones and itching. Each subsequent morning face swelled, and symptoms increased in severity excepting the headache and fever, until September 26th, (the seventh day of the disease, and the fifth day of the eruption) when all symptoms began to abate, except the fever, which went higher.

September 29th, the tenth day of the disease, and the eighth day of the eruption, the objective symptoms were pustular, eruption over entire body, worse on face where umbilication was commencing. Eruption on buccal mucous membrane extending into throat with one on the tongue. In many spots over the body, particularly on palm of hand and face, three or four spots had coalesced, there being on one hand and on one ankle spots the size of a twenty-five cent piece. At this time, the temperature dropped to normal, pulse full, strong but somewhat rapid.

For the first time since September 23rd, fifth day of the disease, patient was able to arise from bed to sitting posture and was quite comfortable though anorexia, sore throat and lameness still continued. Eyes were injected, and soft parts swollen but not sensitive to light although there was an ulceration on one corner. Constipation was maintained throughout the disease. All symptoms prior to September 23rd were necessarily subjective, subsequent to that date, both subjective and objective. This case was classified as confluent.

President:—The paper on "Insanity and Heredity" to be presented by Dr. MacDonald of Concord, will be read by title only, as Dr. MacDonald is not present, and the paper will be given to the Journal for publication.

The paper on smallpox is particularly apropos at present and we will allow ten minutes for its discussion. The paper is now before you for discussion.

I see Dr. Banks of the Marine Hospital in the house, possibly he may have something interesting to say to us on this subject as he must have seen a good many cases of small-pox in his practice.

Dr. Banks:—Mr. President, I did not come prepared to make any remarks before this convention and I am wholly unprepared to make any remarks on the subject of small-pox. I want to thank you, however, for the courtesy of the floor and to say that I am very glad as an old resident of Portland and member of the profession for many years to be again here and have the pleasure of meeting the men I have known for so many years and with whom I have been most pleasantly associated since I began the practice of medicine until I came into the service.

Dr. Marshall:—I notice in his paper the writer says that a well done case of vaccination will show in ten minutes whether or not it is successful, but this has not been so with cases I have attended. I have not always had reaction sufficiently marked to tell so quickly; it has occurred to me several times in doing vaccination that I could tell by the results about as soon as the work was completed. It has been my custom to let the place vaccinated dry before covering it and then looking after it very carefully. I have been watching for a good while for an indication that could always be depended upon that the vaccination would take, but I have never heard that statement made before that you can always tell at the time of the vaccination.

Dr. Woodcock—I know of one case that occurred in my experience that appears to be contrary to all these rules and I think it may be interesting to speak of it. We had quite a large epidemic of small-pox quite a number of years ago and a woman was exposed to the disease and exposed some of her family—some of her relatives—in Chesterville. She was about sixty-five years old, and in searching out cases, we got track of her, and in due season she was taken sick. No eruption appeared. I kept looking for the eruption, and except that I found on the palm of one hand, two spots, that was all I could find or I might say all that appeared for we kept a very careful watch. I telephoned Dr. Young about the case and he asked me what I thought about it—had we better continue to keep her in quarantine. We did keep her in quarantine for two weeks and I don't think anybody got to her, but the day after we took the quarantine off, her husband came down with a most marked case of small-pox, as much so as any I had seen at all, and we had had perhaps seventy-five or a hundred cases. He had been vaccinated when he was a young man, and she never had been vaccinated.

Dr. Marsh:—How many years since he was vaccinated?

A.—Oh, it was probably forty or fifty years, fifty years I should say.

Dr. Mitchell:—In a recent epidemic of quite a good many cases of small-pox, in no case was a vaccinated person affected.

President:—The paper now returns to Dr. Marsh. Can you answer all the queries, doctor?

Dr. Marsh:—I am very sorry that as this is not my paper, I am not better prepared to answer these questions, in fact I know very little about this matter; I have seen very few cases of small-pox and really know very little about it from experience. I simply read this paper for Doctor Flint.

President:—I am very glad he did not ask the President to assist him in answering any of the questions, for I never have seen a case of small pox and I hope I never shall.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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*Editorial Comment.**Medical Lectures for the Public.*

Whether lectures on medical topics are actually profitable for people as well as for physicians is rather hard to determine. Such lectures seem to be well attended in Boston and a few other large cities, and professional jealousy has so far not crept in to any alarming fashion because a certain few men have been chosen to lecture publicly, to the exclusion of others perhaps of equal calibre. In smaller cities, such as Maine boasts, such lectures might prove of value, and the lecturers might be chosen by lot and another set of men chosen on repetition of various courses. There can be no doubt that the people need instruction on several points in medicine and public health. The care of the eye and ears, of the general health, of the teeth, and so on, offer abundant topics for consideration.

A good deal of interest has been caused in New York by a series of sex talks to young women by a man physician. Whether such talks are profitable at all; whether they might not be better delivered by a woman is debatable. It would seem as if questions might be more easily drawn from women by a woman. At all events, the present squeamishness concerning sex and syphilis is abhorrent to those who see the ravages of diseases due to ignorance of the laws of sexual instinct and ought to cease. In no way can it be accomplished better than by public talks concerning the relations of the sexes.

J. A. S.

Medical Insurance in Great Britain.

The cry has gone around the civilized world, that Lloyd George, the Chancellor of the English Exchequer has beaten the doctors of Great Britain and Ireland into submission and has compelled them to accept his medical insurance law. This is, however, not true by any means. The British Medical Association has at last voted by a majority of delegates to a final convention to accept the plan as amended by themselves to a large degree, but the London physicians are still holding out fairly well. The physicians elsewhere have really won a victory over the Chancellor because they have forced from him a fee almost twice as large as that which he originally planned and have obtained free choice of physicians to a considerable degree. "A Proper Doctor" means a great deal still, even to the poorest in Great Britain, and insured though they may be that sort of people generally do not like to accept any physician who may be sent to them, but mean, if they can, to have their own doctor.

The greatest opposition to the insurance scheme from the profession, was, and remains, that they hate to be subjected to the beck and call of a sort of Lodge Committee who are unacquainted with disease. They fought to the last, but were finally obliged to accept this insulting part of a very desirable national scheme of insurance against illness of all sorts. They are obliged to accept at the hand of a committee, a majority of whom are laymen, the decision whether or not a person stands in need of medical advice and treatment. If they say that a person needs treatment the committee (panel) doctor must make a professional call.

I have taken pains to look over this enormous scheme with its innumerable sections and exceptions, and it is truly something bewildering. Perhaps the chaotic condition of affairs may be smoothed over but much time will be needed to put matters into proper medical shape. The Chancellor may have compelled many physicians to accept the act for fear of losing their means of living, but he has raised up against himself by his persecutions a tremendous and united political force of medical men who will do their best to drive from office the "hated fellow."

One good point in the law, as now proceeding, is that the doctors will get their pay, such as it is, there will be no bad bills, no waste of postage nor of time in making out and collecting bills. Nor will the physicians' conscience trouble him now, for fear that he may have extorted too much money from one of small means.

The results of this insurance scheme will be watched with interest everywhere for as human nature is mostly sheep-like, similar

schemes will be obtruded upon the attention of American physicians. It behooves us therefore, to study the results of the British insurance law before such plans invade our own practice and endanger our means of living, in a free community. Insurance of the poor and of those of moderate incomes is a useful idea, in the abstract, and it may prove to be so in practice, but one thing is plain, that the carrying out thereof should be largely in the hands of those who do the actual work of fighting and of curing disease; the physicians of today.

J. A. S.

The Scandalous Amount of Medical Work Imposed upon the Doctor by the Insurance Act.

Here is an instance of the results of the new insurance law in England, concerning which even the religious papers in our land are crowing over as the "victory of Lloyd George over the doctors."

A man died in London and as his death seemed worthy of investigation a coroner's jury was called, and the verdict was that the man died from failing to obtain proper medical attention from the insurance doctor of his panel. But what else could be expected! The doctor could not be found soon, for an emergency case. When found, he had more than a hundred people demanding his attention under the insurance law. He sent on a bottle of medicine, and went as soon as he possibly could. But he was too late and the man died from a strangulated hernia. If the physician had had time when he actually called or had enjoyed an early call, he would have hurried the man to a hospital for operation. The jury, after a long investigation, decided that the man died from natural causes, that he might have been saved by an early operation, and that the doctor could not be held blamable for the man's death on account of "The scandalous amount of medical work imposed upon him by the insurance act."

Does Mr. George care for this one death? Not at all so long as he can remain in political power by the votes of people who will soon find out that you can insure against sickness, but that you cannot insure proper care and treatment without sufficient time for examination and diagnosis.

J. A. S.

Correspondence School for Nursing.

We are in receipt of a letter, together with descriptive matter which was received by a member of the Maine Medical Association from the so-called Rhode Island College of Nurses. It certainly deserves a few lines of comment, although it is hardly conceivable that a medical man could be deceived as regards their supposedly liberal offer.

They claim to be organized under the laws of Rhode Island and the purpose is to educate people to become nurses both by correspondence and resident study. Common stock is valued at twenty dollars and the annual tuition is sixty dollars.

The generous offer is that for every fully paid student sent by the doctor, he will receive absolutely free one twenty dollar stock certificate. It is only necessary that he shall refer them and so notify the school in order to receive the above mentioned stock. He is limited to not over five certificates in one year but he will be paid the sum of fifteen dollars cash as a bonus besides the regular dividend for each fully paid student, in excess of above — in other words, as very aptly stated in the opening letter, the college wants to give this particular physician one hundred dollars or more per year during the balance of his life.

It also points out that the doctor can secure the free services of this prospective nurse during her period of training and incidentally give her the instructions as outlined by the school. This is an added inducement to place an unsuspecting mortal into the position of advising some poor girl to tie up sixty dollars in a practically useless object.

They refer obscurely to opening a hospital and note at the same time that correspondence schools are paying big dividends. It is not a philanthropic measure and needs no farther comment on our part.

Natural Sodium Salicylate an Old Fallacy.

Some twenty years ago, when the manufacture of salicylic acid from phenol was a relatively new industry, a few experiments were made which appeared to show that there was some difference in the action of sodium salicylate made from the synthetic salicylic acid and that made from salicylic acid obtained from plants. The difference in effect was ascribed to sodium cresotinate which the synthetic sodium salicylate was at that time said to contain. Cresotic acid bears the same relation to cresol that salicylic acid bears to phenol, and is said to be formed when phenol, which contains cresol, is used in the manufacture of salicylic acid. While, in view of the close chemical relation, it was highly improbable that the action of sodium cresotinate should differ radically from that of sodium salicylate, while the animal experiments were few and not very conclusive and while experiments made on the product of those days can have no bearing on the pure sodium salicylate now available, no attempts have been made since then to confirm or refute these findings. On the contrary, certain pharmaceutical houses have been making good use of these antiquated and doubtful results and have loudly and lustily pronounced the so-

dium salicylate made from other than vegetable source a most vicious and dangerous poison. Happily the Council on Pharmacy and Chemistry now proposes also to shatter this idol of proprietary medicine and as a preliminary step has secured a pharmacologic investigation (Archives Int. Med., Dec. 15, 1911, p. 784) by Dr. Waddell of the University of Virginia, which shows very conclusively that on cats, rats and rabbits, the effects of natural and synthetic sodium salicylate are quite identical. Of course this still leaves open the matter of idiosyncrasy — that is, it is possible that in some way certain patients may have an idiosyncrasy against the synthetic and not against the natural salt but this is not very important. The important fact, which Dr. Waddell has firmly established, is that the claimed toxicity of synthetic sodium salicylate is all “bosh.”

Medical Legislation.

State Hospitals.

Two bills relating to commitment of cases to our State hospitals have been heard during this session of legislature, both of which are progressive. They were accompanied by bills providing for the elimination of the word insane from the designation of our State hospitals. In early days, these institutions cared for the violently insane and were known as “insane asylums.” The study of recent years has shown that nervous and mental diseases include a great many cases, which are not insane as understood by the lay body, and yet require treatment in these institutions. These cases usually recover and become useful citizens.

In our present enlightened age, it is unnecessary to designate our State hospitals as insane, whereas its elimination would break down the greatest barrier against many who would otherwise take advantage of the opportunities offered.

They would sign voluntary commitment papers on advice of family physician, providing he was convinced that such was the wisest course for the patient's ultimate good. It is quite common, in fiction, to have a character confined to an “insane asylum” in order to get him out of the way. Such a thing is impossible in a modern hospital and particularly so in our State institutions with their respective staffs.

Osteopathic Bill.

Hearing before Judiciary Committee, March 11, 1913.

Among the various matters coming before our legislature is an act to regulate the practice of the system, method or science of healing known as osteopathy. This bill provides that the governor, by and with the advice and consent of the council, shall appoint five persons who shall constitute a board of registration of osteopathy. They shall be graduates of a legally chartered osteopathic college or university and shall have been in practice for a period of three years. In the usual manner, it provides for a formation of the board and its perpetuality.

In Section 3, we find the cost of the examination will be twenty dollars while each applicant must at least be of twenty-one years of age, must have a diploma from a high school, academy, State normal school, college or university, or otherwise satisfy the members of the board of sufficient prior academic education. He shall also present a diploma granted by a legally chartered osteopathic college or university in good standing and having the power to confer degrees in osteopathy, which diploma shall show that it was granted on personal attendance of the applicant and completion of a course of not less than nine months in a year for three separate years, or of not less than eight months in a year for four separate years. The applicant must also present a certificate of good moral character signed by some reputable resident of the State of Maine.

Section 4 is the most important as can be readily seen in its provisions. The board shall then require the applicant to submit to an examination as to his or her other *qualifications for the practice of osteopathy which shall include*, among other subjects, the subjects of anatomy, physiology, chemistry, bacteriology, toxicology, pathology, dietetics, diagnosis, hygiene, obstetrics and gynecology, minor surgery, principles and practice of osteopathy, etc., etc.

In Section 6, we find that anyone who shall use any of the forms or letters, "osteopathy," "osteopath," "osteopathist," "D. O.," "D. Sc. O.," "osteopathic physician," "doctor of osteopathy," *or any other title or letters, either alone or with other qualifying words or phrases*, under such circumstances as to induce the belief that the person who uses such term or terms is engaged in the practice of osteopathy, without having complied with the provisions of this act, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be fined not less than twenty-five dollars, nor more than one hundred dollars, for each offense, or not less than three months, nor more than six months in the county jail.

Section 12, eliminates clairvoyants or persons practicing hypnosis, magnetic healing, mind cure, etc., or any other method of healing, providing said clairvoyants and other persons do not violate any of the provisions of the preceding section in relation to the use of the word "doctor," or the latters, "Dr." when used in connection with the words or letters "osteopathy," "osteopath," "osteopathist," "D. O." "D. Sc. O.," etc.

Finally Section 18. All acts and parts of acts conflicting with the provisions of this act are repealed in so far as they are inconsistent herewith.

State Board of Medical Registration.

At a hearing before the judiciary committee on February 21st, two members of the board appeared before the committee urging changes in our present law, notably among these was a provision to legally establish the personnel of the board which is composed of four regular physicians and two homeopaths. In Section 11 and 12, it specifies that any graduate of "an accredited medical college" instead of "a legally chartered medical college" as appeared in the old bill.

One of the weakest points in our present law, so far as it aims to close out the worst type charlatan, appears in Section 15, where the adjectives, *poisonous* and *dangerous*, appear before the word drugs. In the new bill these two adjectives are omitted.

The only other change of note is in relation to the funds of the board. The new bill provides that all moneys paid into the board shall be placed at its disposal in order that it may print annual reports of what it is doing, also send delegates to national or state meetings, both of which should be done. There are also minor changes.

The writer attended this hearing with a feeling of doubt as to the advisability of the bill coming up at this time, but after listening to the objects aimed at in the bill as presented by the two members of the board, he was firmly convinced of its justness.

There seemed to be two main opposing factions to this measure, the most prominent of which was Dr. Mayberry of Saco, who was supported by some of the medical members of the House and Senate. The next strongest opposing body was magnetic healers.

Dr. Mayberry's opposition seemed to lie mainly in the provisions of the bill which required that any graduate of an *accredited* medical college shall, etc. It can readily be seen that almost any type organization with any standard whatever, might become a legally chartered medical school whose graduates could appear before this board for an examination. It is true that they probably would not pass the board but where is the advisability of allowing them to come before it? This board is organized under a State law to carry on a specified work and the remuneration is extremely small for the amount of time necessary so that in justice to them it would seem wise to limit their work to only what is absolutely necessary.

The doctor also referred to the provision whereby the funds of the board shall revert back to the board. It seems under the present law some seven or eight hundred dollars each year is turned into the State treasury by the board, whereas it is impossible for them to secure money to print the annual report or, in fact, make permanent records of any value. It is unnecessary to argue the advantage of having a member of our board attend a national meeting of State boards of registration. Even the day laborer knows that a delegate from his labor union to a State or national convention brings back its reward in proportion to and above the expenditures and how any intelligent, educated man can argue against such measures being adopted by a body of this kind is quite beyond comprehension, barring political motives.

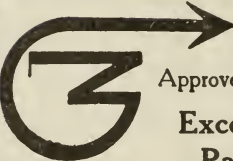
The most important part of the bill lies in the two words "poisonous and dangerous" and here the medical profession are credited with a desire to create a medical trust whereby the magnetic healers would lose their legal rights to dispense pennyroyal tea and other similar remedies. A most superficial survey of the medical profession would convince these people that, under the present or past laws, the medical profession has never attempted or advocated prosecution of any person who was not openly violating such laws. On the other hand, practically every physician has at his fingers' ends sufficient data to prosecute some few respectable individuals. As the old law stands it is possible for any charlatan to come into the State, do a large business, and then move on to the next State without being disturbed by our local authorities.

It has not been possible to get a county attorney to proceed against any of these cases under the present law. All respectable citizens, including the magnetic healers, are just as anxious to have this type of individual eliminated from our State. It would seem, however, that their fears of what might happen so far exceeded their good judgment based on what has happened that they have reached a state where judgment is impossible.

As regards the medical trust referred to by opponents of this bill, it would seem almost unnecessary for anyone to deny its existence. The medical man's only asset is his knowledge and to found a trust on knowledge alone requires a most active imagination.

An organization of the medical schools of the country is equally impossible in that each school is controlled by its own body of directors or overseers whose interests are local and, although anxious to raise the standard of their schools, they will oppose outside interests as to methods of running.

The writer feels that the law as submitted this year should have received the support of the medical profession as it has suggested valuable changes. Apart from the medical members of the House and Senate and members of the board, there were present, Dr. Marsh, Guilford, President of the Maine Medical Association, Dr. D. A. Rob-



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inson, Bangor, Chairman of the State Legislative Committee, Dr. Mason, Bangor, and Dr. J. B. Thompson, Bangor, both of whom were sent as representatives from Penobscot County Medical Society, Dr. E. E. Holt of Portland, President of the Cumberland County Medical Society and the writer.

EXAMINATION OF CANDIDATES FOR ASSISTANT SURGEON.

TREASURY DEPARTMENT,
UNITED STATES PUBLIC HEALTH SERVICE,
WASHINGTON, D. C.

A board of commissioned medical officers will be convened to meet at the Bureau of Public Health Service, 3 B Street, S. E., Washington, D. C., on Monday, April 7, 1913, at 10 o'clock A. M., for the purpose of examining candidates for admission to the grade of assistant surgeon in the Public Health Service.

Assistant surgeons receive \$2,000, passed assistant surgeons \$2,400, surgeons \$3,000, senior surgeons \$3,500, and assistant surgeon generals \$4,000 a year. When quarters are not provided, commutation at the rate of \$30, \$40 and \$50 a month, according to the grade, is allowed.

For further information, or for invitation to appear before the board of examiners, address "Surgeon General, Public Health Service, Washington, D. C."

Book Reviews.

The Practice of Gynecology.

Fifth edition, thoroughly revised. A text-book on the practice of Gynecology. For Practitioners and Students. By W. Easterly Ashton, M. D., LL. D., Professor of Gynecology in the Medico-Chirurgical College of Philadelphia. Fifth Edition, thoroughly revised. Octavo of 1,100 pages, with 1,050 original line drawings. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$6.50 net; half morocco, \$8.00 net. W. B. Saunders Company, Philadelphia, London.

The fact that this book has been through five large editions and as many reprints in seven years is sufficient evidence that there was a need and place for such a treatise on gynecology. The leading idea of this work has been its careful detailed description in outlining either medical or operative treatment. "Nothing is taken for granted," is the way the author puts it. If one starts to read through a work of this kind, he will consider it a bit tedious because of its repetitions but this is more than offset by the great value of it as a reference book. In looking up any special disease in a hurry, he will find under that heading the whole story, without reference to other sections. Thus to the general practitioner, Dr. Ashton's book has made the greatest appeal. The present edition is brought well up to the minute.

P. P. T.

International Clinics.

Volume IV. Twenty-second series, 1912. A quarterly of illustrated clinical lectures and especially prepared articles by leading members of the medical profession throughout the world. Philadelphia and London. J. B. Lippincott Company. Price, \$2.00.

We have at hand the fourth volume of International Clinics which like its predecessors has aimed to cover the diagnosis and treatment of medicine, surgery, gynecology and a chapter on economic medicine, closing with a final chapter on the Relation of Prison Life to the Development of Insanity among Prisoners. To the readers of the International Clinics, it is unnecessary to enlarge farther than to say it is a commendable work.

SURGICAL SUGGESTION.

Blood pressure observations every few minutes are essential to the safe conduct of intracranial operations.—*American Journal of Surgery.*

Review of Current Literature.

Journal American Medical Association, Jan. 13, 1913.

Theory and Practice of the Treatment of Sterility in Women.

Edward Reynolds, M. D., Boston.

The author realizes that treatment of sterility has long been one of the failures in the practice of gynecology, and takes up some minor as well as major points that should be looked into in the treatment of the condition. All of the deranged conditions must be restored to normal, and if possible simultaneously. The conditions that affect the spermatozoa most deleteriously are the hyperacidity of the vaginal secretion, and the abnormal condition of the uterine secretion, which may have been brought about by any one of several causes, for example, hypercongestion of the uterus and surrounding organs, smallness of the cervical os, or diseased mucous membrane of uterus or a tube.

The ovum may be affected by various conditions of the ovary, or tube, but besides those generally recognized as gross lesions the writer takes occasion to call attention to the fact that there may be a tube occluded at one end that it is impossible to detect upon examination, and that an ovary which although not diseased, is semi-cystic may have to be improved before fertilization can take place.

Examination of the fertility of the husband should not be omitted before any operative procedure on the wife is undertaken.

These minor points, slight corrections that may be made in the wife, are often productive of very gratifying results.

H. J. E.

The Application of Iodine to the External and Internal Genitals.

J. W. Bovee, M. D., Washington, D. C.

The writer having experimented with various solutions of iodine in this sort of work, advises that he has found the most efficacious and least productive of bad results a 3½% solution in 95% alcohol. This he uses not only in preparation of the skin before operation, and for sterilization of the vagina, but also in the cure of infections of the vaginal tract, as application to the peritoneum and tubes in the course of an abdominal section, and for injection into the Fallopian tubes by way of the uterus for certain diseased conditions of these structures. His methods are explained with exactness.

American Journal of Obstetrics, February, 1913.

When Is the High Forceps Operation Justifiable?

James A. Harrar, M. D., Attending Surgeon, Lying-in-Hospital, New York.

From all collected statistics as well as from his personal experience, the writer considers that high forceps operations are less dangerous than version to the child. However, there are occasions when it is the best procedure, some of the conditions being (1) dry labor in normal pelvis, with formation of contraction ring, or (2) rigid cervix and (3) moderately contracted pelvis when moderate pulling will engage the head in the inlet to the pelvis. High forceps should never be selected before labor as the operation of choice, and should always be done by the specially trained operator. The Walcher position, and pubiotomy are considered as aids to the operation of high forceps rather than a distinct method of delivery.

Treatment of Skull Fractures in New-Born.

George W. Kosmak, M. D., Attending Surgeon, Lying-In Hospital, N. Y. City.

Later complications of a simple depression in the skull at birth are so usual, that it is best to correct these conditions when it is a simple matter. A careful examination of the skull of the infant should be made after operative delivery. Attempts at replacement of the depressed portion of the bone by manual compression should not be made, as there is great danger of causing an intracranial hemorrhage. A simple hook that is inserted through the innertable of the cranium is best for getting control of the bone, and for preparation, clipping of the hair, and application of iodine is all that is necessary. Although some other instrument may be improvised, the author has designed an instrument for this specific purpose which gives the operator a good grasp.

H. J. E.

From the American Journal of the Medical Sciences, Dec., 1912.

Indicanuria.

By Wm. Gerry Morgan of Washington, D. C.

This paper deals with the observations of the author upon 148 patients whose urine showed indican.

The indican itself is non-toxic but the aromatic bodies such as indol, skatol, etc., which are the results of proteid decomposition, are toxic and from these the indican is formed. Indol is the result of putrefaction of the proteids and the lower ileum is the chief seat of its formation, the colon being the absorptive seat.

Of the 148 cases studied, 73 occurred in females and 75 in males. The cases of pure intestinal auto-intoxication were rare, most of the patients presenting symptoms of other gastro-intestinal disturbances. 92 of the 148 cases occurred in the first six months of the year, hot weather not causing an increase in the excretion of indican. No definite etiological factor was present in any considerable number of cases. In 113 patients gastric analyses showed hyperacidity in 46, subacidity in 25, and normal in 42. Baar considers hyperacidity with indicanuria as a diagnostic sign of ulcer.

Constipation apparently has no part in the causation of the indicanuria, some of the worse cases having normal stools daily. Indican is increased in peritonitis, typhoid, cholera and after operations in which the intestinal walls are cut or roughly handled. The most frequent cause, according to the author is improper diet complicated with loss of nerve tone.

The typical symptoms are vertigo, headache, languor, drowsiness, depression, irritability, gas in the bowels and muscle cramps. 95 patients complained of gas in the bowels, 62 complained of headache, 45 of dizziness, 32 of early fatigue. Pain in the muscles, although rare, is quite characteristic when present. Other symptoms are hazy spells, palpitation, cold hands and feet and numbness. None alone are characteristic but a combination is suggestive.

The treatment consists in eliminating the primary cause of the putrefaction by means of diet, exercise, irrigations and occasional medication.

J. B. DRUMMOND.

Surgery, Gynecology and Obstetrics, November, 1912.

Experiments in the Treatment of Acute Anaemia by Blood Transfusion and by Intravenous Saline Infusion.

BY V. C. DAVID, M. D., AND ARTHUR H. CURTIS, M. D., CHICAGO.

From the Memorial Institute for Infectious Diseases.

These experiments carried out on dogs since 1909 have embraced three operations, namely: (1) intravenous infusion with 0.85 per cent saline solution; (2) transfusion of blood; (3) intravenous injection of defibrinated fresh blood. In each instance bleeding from the carotid artery was carried either to a point of high anaemia or to the point of death, and then the three methods were compared as to their efficacy in restoring the disturbed conditions. The results clearly indicated: 1st, That salt solution usefulness is limited to a few hours until preparation for transfusion of blood can be made; 2nd, Fresh or preserved defibrinated blood is not to be recommended; 3rd, Blood transfusion is the treatment of choice in severe anaemia, as its effects are not only prompt but lasting.

E. E. H., JR.

County News.

CUMBERLAND.

The first regular meeting of the Cumberland County Medical Society for 1913 was held at the Congress Square Hotel, Friday evening, February 14th, at eight o'clock. After the transaction of regular business, Dr. John Homans of Boston read the paper, his subject being "Treatment of Varicose Veins and Varicose Ulcer." The paper proved to be very interesting and was followed by a free discussion. There was an attendance of sixty-three, including several guests from York and Sagadahoc Counties.

(April meeting.)

It is now planned to hold the next meeting of the Cumberland County Medical Society on Saturday evening, April 19. We are considering ourselves very fortunate in being able to procure Dr. William Seaman Bainbridge of New York, who will read a paper on "Chronic Intestinal Stasis." The paper will be illustrated by stereopticon slides. Dr. Bainbridge is one of the most active of the younger surgeons in New York City at the present time and those who were present at the last Congress of the Clinical Surgeons of North America held in New York in November, will testify as to Dr. Bainbridge's ability.

P. P. THOMPSON, *Secretary*.

PORTLAND MEDICAL CLUB.

The first meeting of the year was held at the Columbia Hotel, on January 2nd, 1913. No formal paper was presented, the evening being devoted to a discussion of the Portland Health Department. There was a large attendance, and most of those present had some opinion to express as to what would constitute an ideal Board of Health for Portland. At the conclusion of the meeting, it was voted that the committee of the club on Board of Health matters be given further time in which to formulate and present a report.

Several interesting cases were reported, notable among them being the cases of poisoning from nitric acid fumes which recently occurred in the Portland fire department.

R. B. MOORE, *Secretary*.

The second meeting of the year was held at the Columbia Hotel, February 6th, 1913. The paper of the evening was by Dr. E. E. Holt, Jr., his subject being "Iritis: Its Diagnosis and Treatment." Special emphasis was laid on the diagnostic point that a pupil which will not

dilate in the dark is significant of iritis. The paper was discussed freely by the members.

Drs. W. L. Quennell and James D. Clement were elected to membership in the club.
R. B. MOORE, *Secretary*.

HANCOCK.

On Wednesday, February 19th, the Hancock County Medical Society held a public tuberculosis meeting at the Y. M. C. A. building in Bar Harbor. The meeting opened at 8 p. m., with Frank R. Ober, the president, in the chair.

Dr. A. A. Downs, of Fairfield, Executive Secretary of the Maine Anti-Tuberculosis Association, read a very interesting paper on "Methods of Prevention and Treatment of Tuberculosis." Dr. W. C. Peters, of Bangor, President of the Maine Anti-Tuberculosis Association, gave an excellent talk on "Other forms of Tuberculosis than those commonly known as consumption, with special emphasis on the forms which cause deformities."

A large number was present at this meeting and a committee was appointed to form an Anti-Tuberculosis Association in Bar Harbor. After the adjournment of the meeting, the physicians repaired to the residence of Dr. R. G. Higgins, where a bountiful repast was served and a social hour enjoyed.
FRANK R. OBER, *County Editor*.

KNOX.

The regular meeting of the Knox County Medical Society was held in Rockland at the Thorndike Hotel on February 11th.

Dr. C. B. Witherle of Portland gave a talk on "The Syphilitic Diseases of the Nervous System."

In anticipation of a medical treat, several of our members put forth an especial effort to attend the meeting, driving a long distance in the storm, and are willing to repeat the performance when the genial doctor favors us with his presence again.

At the end of the talk, a rising vote of thanks was given to Dr. Witherle.

The next meeting will be held on Tuesday, April 8th, at the Thorndike Hotel.

H. W. FROHOCK, *Secretary*.

PENOBSCOT.

The Penobscot County Medical Association held its usual monthly meeting at the Bangor House, Bangor. There were no papers, a social time being enjoyed.

A committee of three was appointed, Drs. Brown, McCann and Robinson, to confer with the Eastern Maine General Hospital Trustees,

to see if some arrangements could be made whereby patients occupying private rooms could be made to pay a surgical or medical attendance fee.

Dr. Harvey and Dr. Robinson spoke in regard to the legislation coming up at Augusta. Two members were appointed to go over to Augusta with Dr. Robinson, when the matter should come up. Dr. W. C. Mason and Dr. J. B. Thompson were appointed.

Two new members were admitted to membership, Drs. R. Lee Mitchell of Carmel and A. A. Brown of Bangor.

The meeting closed at a late hour.

J. B. THOMPSON, *Secretary*.

YORK.

A free public lecture was given at the McArthur Library auditorium, Biddeford, Friday evening, Feb. 21. The meeting was held under the auspices of the York County Medical Society and the speaker was provided by the Council on Health and Public Instructions of the American Medical Association. Dr. John Lovett Morse of Boston, Assistant Professor of Children's Diseases in Harvard Medical School, delivered an address on the subject, "The Care and Feeding of Young Children." Dr. Morse is thoroughly prepared to discuss such a subject and he brought out and explained in an interesting and instructive manner many valuable points. The meeting, although not largely attended, was a successful one and cannot fail to be productive of much good.

Following the lecture, members of the York County Medical Society entertained Dr. Morse at a lunch given at Hotel Thatcher. It was an occasion of much social enjoyment.

A. L. JONES, *Secretary*.

NOTICE.

Any member in good standing in the State Association, wishing to serve as a delegate to the meetings of other State Societies, should communicate with the President, Dr. R. H. Marsh, Guilford, at an early date.

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PERSONAL NEWS AND NOTES.

Dr. and Mrs. D. J. Clough of Portland have returned from their southern trip.

Dr. and Mrs. E. G. Abbott of Portland, sail from New York on March 5th, for Paris and Berlin. In Paris, before the International Congress of Physical Education at the Sorbonne and in Berlin before the German Orthopedic Congress, Dr. Abbott will, by invitation from these bodies, lecture upon and demonstrate his method for correction of scoliosis.

Dr. James A. Spalding of Portland read a paper before the Maine Historical Society Thursday afternoon, February 27th, entitled, "Life of Dr. Aaron Young, Jr., first State Botanist of Maine and first ear surgeon."

Owing to unavoidable circumstances, Dr. Adam P. Leighton, Jr., was unable to formally open the private maternity hospital as had been previously announced. The hospital is now open and trust it may be favored with your early inspection.

Dr. Lawrence E. Willard has been nominated as the candidate for Mayor of Saco on the Democratic ticket.

Drs. E. D. O'Neill, H. W. Hurd and G. C. Precourt are candidates for the Board of Aldermen on the new Citizens Party ticket in Biddeford.

Dr. J. D. Cochrane is an aldermanic candidate in Saco. He is a Progressive. It seems that the physicians in this part of the county are especially interested in political affairs. Dr. C. M. Sleeper of South Berwick and Dr. H. A. Weymouth have for many years been prominent in local, county and State politics.

Dr. D. E. Dolloff of Biddeford has been mentioned frequently as a mayoralty candidate in that city this winter.

So the public recognizes the advantages of having medical men to represent its interests in the various elective offices. The education and training of physicians fit them especially well to occupy such positions.

Tuskegee Inst., Ala., Feb. 13, 1913. — A \$50,000 hospital to be known as the John A. Andrew Memorial Hospital, given by the granddaughter of the war governor of Massachusetts, will be dedicated at the Tuskegee Institute, Friday, Feb. 21st, 4 p. m. The program contemplates addresses by Hon. Seth Low, Chairman of the Tuskegee Institute Board of Trustees; Principal Booker T. Washington; Dr. John A. Kenney, Medical Director of the Tuskegee Institute Hospital; Dr. George C. Hall of Chicago, Ill.; Dr. U. G. Mason, of Birmingham, Ala.; Dr. W. A. Warfield, Surgeon-in-Chief, Freedmen's Hospital, Washington, D. C., and a post graduate nurse as well as a student nurse. The dedication will take place in the presence of a most distinguished audience.

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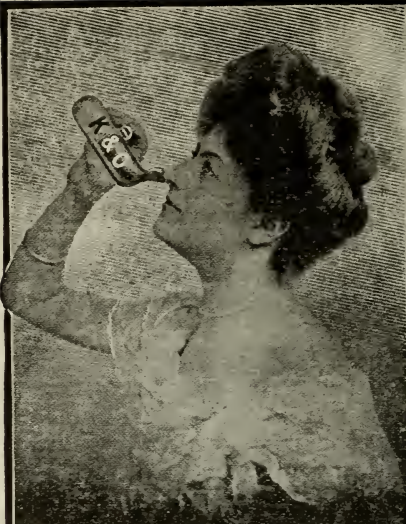
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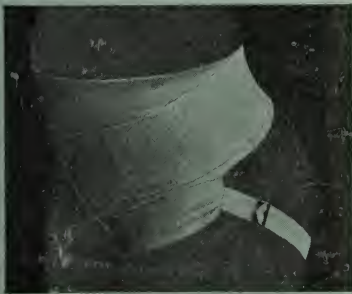
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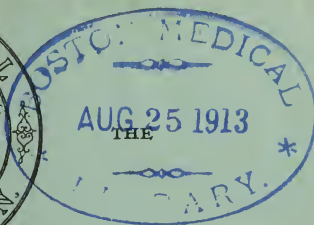
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PRELIMINARY AND POSTOPERATIVE TREATMENT OF ABDOMINAL OPERATIONS.

BY DR. W. L. COUSINS, PORTLAND.

As soon as the patient is admitted and the history taken, we see that the bowels are thoroughly emptied, not by giving large doses of cathartics but small doses of calomel followed by seidlitz powders or teaspoonful doses of saturated solution of sulphate of magnesia in sufficient amount to thoroughly and gently move the bowels, preceded by a high saline enema. The heart and lungs are carefully gone over. Next in order come the kidneys. If the kidneys are not excreting a sufficient amount of urine even though the microscopical quantitative and qualitative analysis shows the urine to be normal in character, we make the sulphone-phenol-phthalin test suggested by Young and Gerharty of Baltimore. If then the quantity of urine is not satisfactory, we institute the Murphy drop method of installation of salt solution by the rectum for three hours twice daily at twenty-five drops per minute. The patient is put upon a nourishing and liquid diet and absolute rest in bed until such time as the kidneys functionate properly if such an end is attainable. We make an especial effort to give these patients large quantities of water, having them take large quantities by mouth during the twenty-four hours, besides the instillations of salt solution. A complete blood count is made before all operations.

It is customary in many places, I understand, for the patient to be operated upon either the day of admission or the following day, but this, in our opinion, is poor treatment. It does not allow the physician to make a thorough and careful examination of the patient

and discover any contra-indication for operation. All our patients, excluding emergencies, are required to remain in bed from three to seven days, or longer if necessary, before being operated upon. On the day previous to operation all receive early in the morning two seidlitz powders, liquid diet, and a high saline enema in the evening. Nothing on the morning of operation save one-half hour before the anæsthetic it is our custom to give a quarter of a grain of morphine with one-hundredth of atropine. This allays the nervousness a great deal and facilitates the administration of the ether which we invariably use.

The principal object gained in this form of preliminary treatment is that it enables the surgeon to carefully examine the abdomen, the bowels being thoroughly emptied and no fæcal masses present to mislead him in his diagnosis. If it is necessary, and it always is in treating a female patient, to make a vaginal examination; unless the bowels are thoroughly evacuated large masses of fæcal matter collected in the rectum often mislead the diagnostician and he may mistake a fæcal mass for a large pus tube or possibly a tumor of the uterus. It has been our experience that patients thus carefully prepared for operation take the anæsthetic better and the postoperative nausea is greatly lessened.

After opening the abdomen following the preliminary treatment one finds that the intestine instead of being greatly distended is collapsed and free from fæcal matter so that should it be necessary to do an intestinal suture, one may easily do it without fear of soiling the abdominal cavity. As to the method of operating following the opening of the abdominal cavity, I would here state that I never make an incision into the abdominal cavity in the ordinary case without making it sufficiently large to admit my entire hand in order that I may carefully explore and examine each abdominal organ. The reason for doing this is that many cases of so-called appendicitis have been operated upon through a small incision, the patient recovering and returns home in a week or ten days only to have a recurrence of the symptoms for which they were operated upon. This is not only discouraging to the patient but is rather embarrassing to the surgeon. Therefore, unless it is a pus case, I feel that it is obligatory on the part of every surgeon to carefully explore the abdominal cavity.

After the operation is completed, we carefully do the toilet of the abdomen, paying particular attention to the replacement of the various organs in as nearly a normal position as we found them, carefully covering the intestine with the omentum, bringing it down beneath the line of incision and into the pelvis as far as possible. This undoubtedly prevents many adhesions, and should adhesions take place, they will occur between the abdominal wall and the apron which

is put there for the protection of the intestine behind. The patient is taken from the table and put to bed, a special nurse is put on guard and as soon as the patient begins to regain consciousness, the Murphy instillation of normal salt solution per rectum is started and continued at the rate of twenty-five drops per minute until the patient begins to expel it, when it is discontinued for three hours. The salt solution is thus intermittently continued for the first twenty-four hours and longer if deemed necessary. For pain, our routine treatment is, unless contra-indicated, to give a quarter of a grain of morphine hypodermically every five or six hours if necessary because in these cases the quieter you keep your patient the better off he is, and if you are positive there is no trouble with the kidneys, morphine is absolutely harmless.

Now the much mooted question as to how much water shall be given the patient is, in my opinion, unnecessary to discuss, but in order to show what we do, I will state here that a patient is given all the water he or she wishes to drink. If nausea or vomiting persists, the patient is given two glasses of warm water which usually causes prompt emesis and very often alleviation of the nausea and vomiting. Should these continue, the stomach is thoroughly washed by means of the tube, thus removing the possibility of acute gastric dilation. Should per chance this latter condition arise, repeated washings of the stomach is its only treatment.

The question arises now as to when to move the bowels. I believe that the earlier the bowels are moved, the more comfortable will be the patient. The relief from nausea will be immediate upon a good evacuation of the intestine. We usually begin on the morning following the operation with small doses of calomel, say one-quarter of a grain every half hour until six doses have been given. In five or six hours, we give the patient a saline enema and the following morning two seidlitz powders one-half hour apart. Should gas become a troubling factor, a series of saline and milk and molasses enemas are given which usually afford very prompt relief. Nothing is given by mouth for the first forty-eight hours but water which is given freely, either hot or cold as to the patient's preference, after which time liquids without milk are given until the bowels have been thoroughly evacuated and gas no longer a factor when liquids with milk are given. Solid food is withheld until the seventh or eighth day, and by the end of two weeks, house diet is administered.

My reason for the above method of feeding is that the rest in bed as well as rest of the gastro-intestinal tract is as an essential a part of the treatment as the operation itself for the majority have over-loaded their gastro-intestinal tract and are suffering from intestinal toxemia.

It is customary for many physicians to permit their patients to sit up in ten or twelve days following the operation and to get out of bed at the end of the second week. We do not consider this a proper treatment for any abdominal case. We do not believe that the abdominal wall has sufficiently healed to permit of the strain which is put upon it, and any patient upon whom it is necessary to operate, to do an abdominal operation particularly, that patient is sufficiently tired to warrant a rest in bed of at least twenty-one days. Perhaps in a case of an old person, I could make exceptions to this rule, but if it is a young person or a person of middle age, I feel that the twenty-one days is far safer than to allow the patient to get up at the end of ten days. This has been my routine for the past ten years and I have gotten excellent results by adhering strictly to it. There is one thing about it; if hernia does unfortunately occur following the abdominal section, you will have the satisfaction of knowing that you did your part toward the healing of the wound. Very frequently we hear our patients say that such and such a physician permitted a friend of theirs to get up in ten or twelve days. That is all very well, but I explain to my patients in the first place prior to the operation that they are to remain in bed twenty-one days and in this manner obviate any trouble which may arise in the future by any misunderstanding.

There is one thing I would like to mention in regard to closing an abdominal section. We use a continuous suture of catgut to close the peritoneum, not tying either end, but after the suture is run the entire length of the incision through the peritoneum both ends of the suture are grasped and tightly drawn, making a purse string which puckers the peritoneum, leaving but a very small part on the inside surface for an adhesion to take place. After the peritoneum is closed, instead of running a continuous catgut suture uniting the fascia, I use an interrupted figure of eight silk worm gut suture through the skin and fascia, not including the muscle. I have demonstrated time and again to my own satisfaction and to the satisfaction of others that this closely approximates the edges of the fascia and there is no buried suture left to cause any irritation. These silk worm gut sutures are removed at the end of fourteen days, leaving the wound free from any foreign body. Two weeks, in my opinion, unless it is a particularly bad case, is sufficient length of time to allow the sutures to remain.

In this brief paper, I trust that I have set forth clearly our methods of doing the ordinary abdominal section without dealing with any special operation. Each operation is done according to the method best understood by the operator.

CERTAIN ASPECTS OF ARTERIOSCLEROSIS.

BY DR. T. J. BURRAGE OF PORTLAND.

Read before the Maine Medical Association, June, 1912.

Of late years the subject of arteriosclerosis has been much before the profession and laity as well, partly at least, through the popularization of Metchnikoff's work entitled, "The Prolongation of Life." You will remember that in his book Metchnikoff analyzes the causes of premature senility and draws the conclusion, that the absorption of toxic material generated by putrefactive bacteria acting on proteids in the colon, is the cause of arterial degeneration. He urges as a cure-all for this condition the avoidance of proteids and the ingestion of lactic acid bacteria which are destructive to putrefactive organisms. Such sweeping statements as these, as to the etiology and treatment of arteriosclerosis must naturally be taken with much reserve, and must be thoroughly investigated before acceptance can be granted them. Combe, in his book on "Intestinal Auto-Intoxication," although following Metchnikoff in the theory that auto-intoxication arises from the decomposition of nitrogenous foods through the action of putrefactive bacteria in the colon, makes no assertion that arteriosclerosis is produced thereby.

Herter, however, believes that premature senility is due to putrefaction caused by the activity of anaerobes, that is, the organisms which grow without the presence of oxygen, especially the *bacillus ærogenes capsulatus*.

With regard to the anti-putrefactive value of lactic acid in the intestine, there is also some debate. Recently Herter and Kendall have investigated the fate of the *bacillus Bulgaricus*, Metchnikoff's organism, in the intestinal tract of the monkey. They were able to maintain an acid reaction throughout the intestine, but failed to establish the predominance of the organism in the iliocaecal region, the seat of most active putrefaction. Oehler, who fed mice and monkeys with Bulgarian sour milk for eight days, could detect no difference in the intestinal flora during or after the experiment, except that the Bulgarian bacillus was found in the faeces while the animals were being fed with sour milk. Two or three days after the feeding was discontinued, the bacilli disappeared. Heinemann, in his extensive experiments with various strains of lactic acid organisms, draws the following conclusions: "The usefulness of lactic acid or lactic acid ferments as a curative agent for intestinal putrefaction is still problematical. Much evidence in its favor, however, has been accumulated, but more scientific observation is needed."

Intestinal putrefaction, moreover, is only one of many causes at work producing arterial degeneration. In an etiological study, Harlow Brooks examined the autopsy material in four hundred consecutive cases of arteriosclerosis to determine the cause. He places alcohol first, as an etiological factor, then nephritis, syphilis, old age, and tuberculosis. Thayer and Brush in an analysis of four thousand cases, report that heavy physical labor gives a high percentage of palpable radial arteries. Camac, in his exhaustive article on "Observations on Aneurism and Arteriosclerosis," finds that arterial disease seems to be attributable to syphilis in about 32% and to tuberculosis in about 16% of cases. Acute infectious diseases also have been found to be potential factors in the production of arteriosclerosis, and Thayer reports that from an investigation of 189 persons, from ten to fifty years of age, recovered from typhoid fever, 48.3% showed palpable arteries as compared with 17.5% in ordinary healthy individuals. Other acute infections also have an etiological bearing, but little appreciated. For instance, Symnitzky, in 138 autopsies on persons under twenty-five years of age, dying of acute infections as typhoid fever, scarlet fever, measles, sepsis, etc., found sclerotic changes in the aorta in 27.5%. Brooks, from his researches draws the conclusion that arteriosclerosis picks out those vessels, which, from one cause and another, are compelled to hyperfunctionate. For instance, the coronary vessels are chiefly involved when the heart is obliged to overwork as in hard labor and chronic nephritis. The abdominal vessels suffer most when the patient is the subject of hyperalimentation. The radial and brachial vessels are apt to be extremely sclerotic in laborers who are constantly using their arms.

During the last ten years, much attention has been given to experimental arteriosclerosis, although it was as far back as 1889 that Lion and Gilbert first brought about vascular degeneration in rabbits by the intravenous injections of bacteria or their toxins. In 1903, Josue produced the first experimental arteriosclerosis by intravenous injections of adrenalin, causing areas of calcification in the thoracic aorta. Since then arterial degeneration in rabbits has been produced by the intravenous injection of many substances, as digitalis, physostigmine, barium chloride, nicotine, phloridzin, lead salts and others. The lesions resemble those of atheromatous degeneration in man being found in the first part of the aortic arch early, and later in the descending portion. Very rarely other vessels are affected, as for instance, the pulmonary artery. Necrosis without inflammation, soon followed by calcification, is the characteristic lesion. Although all investigators agree that arterial degeneration follows the administration of adrenalin in rabbits, its mode of action is still undetermined, some

contending that it is due to a toxic action, others to increased blood pressure, and still others to the cachexia that supervenes upon prolonged adrenalin administration.

In considering the experimental evidence, it must not be forgotten that rabbits may show spontaneous arterial degeneration as has been most ably pointed out by Dr. O. B. Miles of the Pathological Department of the University of Colorado. In a series of sixty-one rabbits treated with adrenalin, 28% showed vascular lesions. On the other hand, in a series of forty-nine rabbits without injections, nearly 35% showed aortic lesions. This indicates that spontaneous sclerosis exists not uncommonly in rabbits of mature age, and that many instances that have been reported as the results of adrenalin may have had their degenerations before the experiment began. The gross appearance of the lesions is the same in the injected and in the non-injected rabbits. It seems reasonable to conclude, therefore, that the various toxic substances used for the experimental production of arteriosclerosis in rabbits, act as more or less powerful irritants upon an already diseased aorta, and render active latent lesions. This is the opinion of most investigators, but until something more definite is proved, final decision on the subject of experimental arteriosclerosis must be held in abeyance.

The present conception of the pathology of arteriosclerosis according to Aschoff, Adler and others, is as follows: "The essential and cardinal pathology of arteriosclerosis is impairment and subsequent degeneration of the elastic elements of the arteries. The succeeding changes in the arterial coats are degenerative and hyperplastic in nature, not inflammatory." The pathological features of the disease will naturally vary somewhat, depending on whether the arteries affected are of the elastic type as the aorta, carotids, and iliacs, or whether they are of the muscular type, as are the majority of peripheral arteries. The more predominant the elastic elements, the more marked will be the sclerotic changes. With regard to syphilitic aortitis, there seems to be some difference of opinion as to its classification with arteriosclerosis of other origin. Adler following Heiberg, Heller and others, feels that syphilitic endarteritis, though often associated with arteriosclerosis, must be classified separately. Miller has the same opinion, stating that syphilitic aortitis is a focal inflammatory process not degenerative, with little or no tendency to calcify, but on the other hand to form cicatricial contractions. Ophuls, however, states that syphilitic aortitis is indistinguishable from arteriosclerosis generally, declaring that "anatomically arteriosclerosis of the aorta is a unit." Whatever may be the minor pathological differences, it seems hardly possible that clinically a distinction can be drawn between the different types

of aortitis or peripheral sclerosis. It is interesting to note in relation to syphilitic aortitis, that Wright and Richardson at the Massachusetts General Hospital, investigating five cases of this disease which came to autopsy, found the *spirochaeta pallida* in the necrotic aortic tissue of all cases.

With regard to the age incident of arteriosclerosis, it is of great interest to observe that many more cases of juvenile arterial degeneration are now being reported. Normally the physiologic process of growth in the arteries reaches its climax in the third decade, and according to Scheel, Bennecke and Suter, this completion of normal growth is followed almost immediately by signs of regression. Thayer and Fabyan have reached similar conclusions from a histologic study of radial arteries. In other words, the first senile changes begin soon after maturity is reached and lead eventually to arteriosclerosis. Dr. F. Fremont Smith of Washington, D. C., has collected from the literature one hundred and fifty cases of arteriosclerosis in youthful subjects, in whom acute infections were the usual etiology. Wiesner frequently found calcifications in the coronaries of individuals between fifteen and twenty-three years of age, dying of endocarditis and osteomyelitis. Wiesel made extensive studies of the heart and blood vessels in three hundred autopsies on young people dying from various infectious diseases as sepsis, scarlet fever, etc. He found lesions in the arteries of nearly all cases, the process being confined mainly to the media, and in many respects resembling the experimental lesions in a rabbit. Hochsinger, though admitting arteriosclerosis to be rare in infancy and childhood, has himself seen aortitis in children eight and ten years of age suffering with congenital syphilis. Chronic aortitis has been observed by Zuber and Guilemot in cases of recurrent articular rheumatism. Sclerosis of the peripheral arteries in childhood occurs almost exclusively in syphilis, and has been noted by Berghinz in infants seven and eighteen months of age. It is thus apparent that arteriosclerosis, at least in its initial stages, occurs not uncommonly in the vessels of young adults, and that in such cases, acute infectious diseases have been the causative factors.

Since the general adoption of the sphygmomanometer some ten or more years ago, many interesting and important facts have been learned with regard to blood pressure in its relation to arteriosclerosis. Most of the early reports were entirely clinical in their nature, but more recently clinico-pathological papers have been published, comparing the clinical findings during life with the post mortem data, thus becoming of much greater scientific value. In most reports systolic blood pressure readings have been recorded, and by most authorities, a persistent systolic pressure of more than 160 mm-Hg. is regarded

as pathologic. Formerly it was generally believed that hypertension was the rule in arteriosclerosis, but more recently it has been established that the tension is frequently normal or subnormal. For instance, Dunin measured the pressure one thousand times in 440 patients with arteriosclerosis and in 27.5% the pressure was normal or low. Groedel of Nauheim, measured five hundred cases of well marked arteriosclerosis and in 35% there was no increase of pressure. Rudolf found that in only about one-half of his cases of arteriosclerosis did the pressure run above normal. This condition of low pressure in arteriosclerosis can be accounted for in one of two ways; either the arteries have not become sufficiently involved, especially in the so-called "splanchnic area," or else the sclerotic process is not accompanied by other hypertensive conditions, as chronic interstitial nephritis, cerebral lesions, or marked cardiac hypertrophy. Sawader has never seen a case of hypertension above 170 mm-Hg. in simple arteriosclerosis. Romberg considers that persistent high tension in a suspicious case establishes the diagnosis of chronic interstitial nephritis. Dr. R. I. Lee of Boston, in a very interesting paper on "Pathological Findings in Hypertension," discusses fifty-three cases from the wards of the Massachusetts General Hospital, who showed a systolic blood pressure of over 160 mm-Hg. and who died and came to autopsy. He was thus enabled to compare the pathologic findings with the diagnosis of hypertension and to determine the cause. He concludes that hypertension occurs most frequently in association with some lesion of the kidney, the most common being the atrophic kidney. Thirty-eight of his fifty-three cases belonged to this group. In the remaining fifteen cases, hypertension was associated with cerebral lesions in seven, and with extensive cardiac disease in seven. In only one of the fifty-three cases was there hypertension due to sclerosis alone without kidney, cerebral or cardiac lesion beyond that of simple hypertrophy.

Walton and Paul in their article on Arteriosclerosis found that the average systolic blood pressure in 100 cases without cardiac or renal involvement was 147 mm-Hg., with cardiac enlargement, 168 m. m.; with renal disease 173 m. m. and with both cardiac and renal disease 196 m. m. Whatever the cause of hypertension may be, most authorities, as Janeway, Musser, Miller and others, now agree that high blood pressure is essentially a "conservative process and a physiological necessity, to maintain adequate circulation and to preserve the maximum functioning power of the kidneys." Our conclusion is, therefore, that blood pressure readings by means of the sphygmomanometer are of the greatest importance, and should be taken in every individual of middle age or over who consults us. We must bear in mind, however, that from one-third to one-half of our cases of ar-

teriosclerosis may not show hypertension and that in these instances we shall have to look further for proofs of arterial degeneration.

In dealing with the symptomatology of arteriosclerosis, the writer will consider briefly only those symptoms associated with the three complexes; cerebral arteriosclerosis, angina abdominalis and intermittent limping. Walton and Paul in their clinical article on arteriosclerosis, point out that there is a growing tendency to attribute nervous symptoms to arterial degeneration. To test the correctness of this view, they examined one hundred patients with marked arterial degeneration with special reference to the presence or absence of symptoms usually attributed to cerebral arteriosclerosis, as headache, vertigo, apoplectiform seizures of transient nature, aphasia, loss of memory, insomnia, and emotional changes. After careful examination of their material they came to the following conclusions, namely: that arteriosclerosis is directly productive of vertigo and transient apoplectiform attacks, and plays a part in the loss of memory and failing mental powers, but that it has little to do with headache, insomnia, or emotional changes. They also believe that spasm of the cerebral vessels, the so-called vascular crisis of Pal, or inadequate circulation resulting in poor nutrition of the brain tissue are often the causes of the above mentioned symptoms rather than that they are the result of thrombosis or hemorrhage.

The subject of abdominal arteriosclerosis has been attracting considerable attention of late years. Ortner, Pal, Perutz, Huchard and others have thoroughly investigated this condition. Ortner in particular has reported extensively a case of general arteriosclerosis, involving especially the superior and inferior mesenteric arteries, and through them the intestinal wall. This condition was associated with severe umbilical pain, two or three hours after meals, gaseous distention, difficult respiration and explosive belching. Ortner's explanation of these phenomena is that the thinning of the intestinal wall with a consequent loss of motor, secretory and absorbing function is directly due to the thickened and calcified aorta and mesenteric arteries. Kreuzbuchs, in his article on "Angina Abdominalis" reports six cases with ages ranging from forty to fifty years. The principal symptoms consisted in paroxysmal attacks of pain in the umbilical or epigastric regions associated with tympany, and following exertion. The blood pressure was variable. The principal physical signs were marked tenderness over the abdominal aorta and sclerotic changes in the heart and peripheral arteries.

Intermittent limping, a condition due to sclerosis of the arteries of the legs, is an important clinical entity. Erb, who has made a compilation of one hundred and twenty cases, reports a new series of

thirty-nine. It is a striking fact to learn that in this total of one hundred and fifty-nine cases, only nine were women. Erb found that the abuse of alcohol and tobacco, and exposure to cold were the chief etiological factors, syphilis being causal in only three cases. General arteriosclerosis was present in 85% of all cases. There are four cardinal symptoms of this disease; the intermittent character of the painful limping; the prompt appearance of pain and limp on exertion; the absence of pain when the leg is at rest, and the absence, especially during the attack, of pulsation in the dorsalis pedis and posterior tibial arteries. Examination reveals a calcified condition of the arteries which is also well shown by radiographs.

The treatment of arteriosclerosis can only receive the briefest attention in this paper. It must be apparent from what has been said thus far, that arteriosclerosis uncomplicated, rarely presents marked hypertension, and that when this does occur it is because of an associated kidney, cardiac or cerebral lesion. Again it has been shown by such men as Janeway, Musser, Miller and others, that hypertension is not necessarily an indication for active therapy, but is rather a conservative process to maintain circulation at its best, and the secreting function of the kidney. Loeb has shown that lowering the blood pressure thirty-five to forty-five mm-Hg. by nitroglycerine leads to a diminished elimination of water and urinary solids. However, reduction of blood pressure is desirable in certain cases, as it relieves some of the unpleasant symptoms. According to Miller, the vasodilators, nitroglycerine, sodium nitrite, and erythol tetranitrate are all transitory in their action, and in some cases without any effect whatsoever. Of these preparations, the best are sodium nitrite and the alcoholic solution of nitroglycerine. Sweats and venesection, especially the former, are of value as vasodilators. Miller, in one of his articles, concludes that, "with the increasing tendency to assume that hypertension is compensatory in character, the only rational treatment is the removal of the cause if possible." Therefore, if the etiology of the arterial degeneration is alcohol, syphilis, auto-intoxication, tuberculosis, or hard physical work, these conditions must be rectified if other subsequent therapeutic efforts are to be effectual. As far as diet is concerned and it apparently is of great importance, proteid food should form but a very small part and the balance of the caloric needs should be made up of digestible starches and fats. Moreover, what small amount of meat is used should not be of the cold storage variety, and must be perfectly cooked and thoroughly masticated, to prevent putrefaction.

If more strict measures are necessary, proteid food should be entirely excluded from the diet, lactic acid tablets of lactic acid milk

should be ingested and high saline irrigations practised. Exercise, especially if out of doors and if followed in moderation, is undoubtedly of great value in arteriosclerosis, but overexertion and fatigue are exceedingly harmful as the writer has had ample opportunity of observing. The restriction of liquids and sodium chloride must be enforced in cases of arteriosclerosis complicated by cardiac or renal dropsy. As far as drug treatment is concerned, iodine in the form of some of its salts is the most efficient remedy that we possess. It must be taken for many months and often in increasing doses to prove most beneficial. Just how the iodides produce their remedial results is not known, since it has been definitely proved that they do not lower blood pressure. Theobromine in the form of some of its combinations, as diuretin is also a very useful drug in overcoming vascular spasm, since it is a reliable vasodilator. Of late years electricity, especially the high frequency current, has been extensively used and recommended, as an agent for lowering blood pressure, but as yet, reports on its value are conflicting. With regard to the effect of thiosinamin and antisclerosin, little that is definite can be said.

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Discussion opened by Dr. Edwin Gehring.

Dr. Gehring:—Mr. Chairman and Gentlemen—Dr. Burrage's paper presents many interesting points for discussion of which time will permit me to mention but a few. First as to the causes of arteriosclerosis. By actual count, seventy-one causes have been enumerated. These, may, however, all be reduced to three and can be described in the following manner—time, tension and toxins. In the elderly individual, the time element is the one that predominates; in the individual suffering from syphilis, the toxic element prevails and in the individual suffering from nephritis, both the toxic and tension elements must be taken into consideration. There is one toxic element that to me seems to be responsible for more or less of arteriosclerosis, as well as many of the others on which much stress is laid, and that is the habit of eating and drinking, and I would lay special emphasis on the eating. We all know what alcohol will do,

and it is reputed to do some things which it does not do, but we have not, it seems to me, laid enough stress on the harm coming from over-eating, and it is from over-eating that we get many of our bad effects, and this is particularly true in arteriosclerosis. The second point to which I will call your attention is that of high tension, and as this is sometimes considered a sort of physiological affair, we are not to make an attempt to reduce that tension in certain cases. One may have arteriosclerosis without high tension, and one may have high tension without arteriosclerosis. On the other hand, one may have nephritis which may be produced in one of several ways, and not have high tension. One thing in particular which interested me in his paper is that headache is not regarded as a consequence of arteriosclerosis. I think nearly every other authority has referred to it as one of the symptoms, but Dr. Burrage seems to consider vertigo rather more important than headache.

Dr. Jefferson:—Mr. President and Gentlemen—I want to say just a word on this subject. This is the type of disease that I like to reduce to its least common denominator, so to speak, and I think I can reduce it to one. I agree with Dr. Burrage in many of his conclusions. As I understand the symptoms and the whole article, if you have followed it—if you trace the symptoms back, you will naturally see that it is the one condition of retention. Dr. Gehring has spoken of the causes as being time, tension and toxin, and those are the three elements you get in retention.

President:—I want to say that we have with us a distinguished gentleman from New York, who will later be heard officially. I have the pleasure of introducing Dr. Cragin of New York, and I wish to extend to him the privilege of the floor in all questions of debate which may come before us. Dr. Cragin, gentlemen.

Dr. Jackson:—I was sorry to have Dr. Burrage's paper cut off so shortly, as I would like very much to hear what he has to say in regard to the matter of treatment. I think we would all be interested in hearing a description of his treatment on that subject.

Dr. Barrett:—I have been treating cases of this kind for the past few years by electricity, and have had very good success. I have found in cases that I have treated that I have been able to reduce the hypertension from ten to twenty degrees in one treatment, and by constant treatment we have reduced it to normal. I have one case of a woman who had been under treatment with different physicians and had received only temporary benefit. When she came to me I found the hypertension to be 210. I gave her the treatments with nothing else and after reducing the tension to normal she entirely recovered her health and has been well for a year. The trouble previous to this had been running for several years and she was in poor health most of the time.

President:—Is there anything further to be said on this subject? If not it returns to Dr. Burrage.

Dr. Burrage:—With reference to Dr. Jackson's question in regard to the treatment used. Miller says that the only rational treatment is the removal of the cause, if possible. I think one of the most important matters is to correct the diet; as far as drug treatment goes I have secured good results with iodine in the form of some of its salts, and perhaps this is the most efficient remedy that we at present possess. I believe that if this is taken for a long enough time—six months or a year, and increasing the dose if necessary, perhaps taking fifty drops three times a day, it will relieve the sclerotic symptoms. Exercise, particularly if out of doors, and not overdone, is undoubtedly of great value in the cure of arteriosclerosis, but over-exertion is exceedingly harmful, as I think probably we have most of us had occasion to observe. Exercise and diet really play a remarkably important part in the cure of this disease.

EVILS CAUSED BY POOR DEVELOPMENT OF THE UPPER JAW.

BY S. J. BEACH, M. D., OF AUGUSTA.

Read before the Maine Medical Association, June, 1912.

A narrow mouth with a high arched roof so frequently accompanies adenoids, that even the laity speak with contemptuous familiarity of the adenoid face. It has been the commonly accepted belief among doctors and patients alike that the facial deformity results from mouth breathing, aided and abetted by thumb sucking; that is, we have assumed that the adenoids have come first and that the facial deformity has followed. Most recently we have been told by the dentist that we are as usual mixed as to cause and effect, and that the malformed jaw causes the adenoid hypertrophy. This is by no means its only offense. Specialists in the last few years have become impressed with the broad variety of ills attendant upon this deformity of the face. And in the few minutes devoted to this paper, I wish roughly to outline the more important. The anatomical side of the subject is a very plain mechanical proposition. The bones involved are the superior maxillæ. They are the largest bones of the face, enclose the nose, roof the mouth, floor the orbit, and drain the sinuses. Without making this an anatomy recitation and naming the nine bones with which each articulates, it is safe to assume that the strategic position of those bones is obvious. Organs of special sense — eyes, ears, nose and mouth, are in close relation. On all these, small deviations produce far reaching results.

The mechanics of the most common malformation, reduced to its lowest terms, is as follows: Squeeze together at the sides a normal upper jaw, and the result is that which would take place in a gable roof if the eaves were approximated — the space in the attic becomes narrow and the ridge pole ascends. Now let us remember in this case the nasal septum rests on the ridge pole, and the outer nasal walls come to the eaves. Consequently the septum, pushed against the roof of the nose, buckles into one or both nares, and the nasal cavity is narrowed by having its lateral walls approximated. The resulting obstruction to the ventilation and drainage of the nose is painfully obvious. If time permitted, it would be interesting to give in detail Mosher's description of the development of the septum and his explanation of the minute anatomy of deviations, the scientific accuracy of which shames the rough illustration I have used. Briefly, after a discussion of the way in which the septum rests in the trough of the pre-maxillary wings, he shows that any deviation either of the in-

cisors in front, or the posterior teeth behind, causing assymetry of the hard plate will cause a vomer spur on one side and a deviation of the septum on the other.

Aggravated forms of malformation are noted in cases of faulty tooth eruption. Here, several or many teeth are either impacted, or erupted outside the dental arch with the crown surfaces pointing outwards towards the cheek. In these cases the dental arch becomes shortened by the space that ought to be occupied by these misplaced teeth, and as it becomes shortened the deformity is like that already described.

This condition has that unfavorable influence on the tonsils and adenoids already mentioned. Dr. George H. Wright (*Laryngoscope* 1909. *Boston Medical Journal*, May 20, 1909), of the Harvard Dental School offers an ingenious explanation. He has observed that at the period of tooth eruption, these organs enlarge normally, without inflammation. He therefore connects them with the tooth formation, believing that they function in the enlargement of the cavities of the face, and other changes of dentition. He concludes that if normal dentition causes temporary enlargement of the tonsils and adenoid, then pathological dentition may produce permanent and pathological enlargement. Whatever the truth of this theory, it is common observation that decayed teeth and inflammatory conditions in the nose enlarge and inflame the tonsils and adenoids in company with the other lymphoid tissue of the throat. It seems probable from the constant enlargement of the nodes in the neck in such conditions, that many cases of scrofula have really been unrecognized disease of the nose and mouth.

We are slowly and painfully learning to seek in pathological tonsils the cause of obscure cases of acute articular rheumatism and chorea, of myocarditis and nephritis, and both tonsils and adenoids are recognized as the offenders in much of the mal-nutrition, anæmia, and even perversion and perhaps insanity of growing children. It now behooves us to trace this evil to its root and examine the soundness of and the regularity of the teeth.

The results of the nasal deformity seem to vary in gravity with ethnic influences. Our race, and the people of Northern Europe, which constitute such a desirable part of our immigrants, have racially narrow faces. It is also true that the Jews, constituting a large fraction of our city population, have narrow faces, the width of the nose being, it is said, 70% of its height. Obviously, therefore, in this large proportion of our patients, a very slight deviation in the air passages will cause profound obstruction to ventilation and drainage. This is the fertile source of most of the suffering which seeks

the otolaryngologist for relief. Mouth breathing I have mentioned. Nasal catarrh of all sorts, from simple tendency to colds, to those cases of hay fever which seem to be actuated by a spur or other nasal lesion, and those headaches which are relieved by separating a contact between the middle turbinate and the septum are conditions for which this deformity is frequently responsible. More serious are the effects upon the nasal sinuses. The ears, anatomically speaking, are essentially sinuses of the nasopharynx. Upon the ear, nasal catarrh and obstruction from any source start the same train of evils. I may be pardoned for enumerating the elementary sequence eustachian catarrh otitis media, mastoid abscess and sinus thrombosis, meningitis, and brain abscess, which may originate simply and gracefully from this nasal deformity. We see frequent cases of mastoiditis due to this type of nasal obstruction.

Nasal sinus disease, both catarrhal and suppurative, is believed to be due primarily to the obstruction of that small area into which empty all the principal sinuses. This space has been felicitously christened by Ballenger, the vicious circle of the nose. A high deflection of the septum is a fertile cause of obstruction here, and this again is often due, as has been said, to a malformed jaw. Nasal polypi, and even ozæna, are attributed by many to sinus disease. Extension to the meninges and the orbit is by no means rare.

All the facts stated so far have been proved. In the speculative field, Dr. G. V. I. Brown, a dental surgeon who has done pioneer work, suggest the deformities in the orbit produced by malformation of the superior maxillæ may have bearing in the formation of refractive errors and faulty balance of the ocular muscles. He cites a case of strabismus which was apparently relieved by separating the maxillæ. When we realize that a hyperopic eye is one that is short and a myopic eye is a long one, and that less than one millimeter in length causes a difference of three diopters in refraction, it is easy to imagine that a malformed orbit can, by misshaping the globe, cause a marked refractive error. Remembering the number in degrees of strabismus that are overcome by an almost imaginary shortening of a tendon, it is easy to believe that a slightly deformed orbit may be responsible for a marked muscle error. This phase of the problem is admittedly theoretical. There are, however, ocular lesions on which nasal conditions are known to have profound effect. Not only does nasal obstruction cause infection of the nasal duct and lachrymal sac, but any disease of the nasal mucosa may establish an eczematous conjunctivitis or keratitis. Repeatedly we note the recovery from vague ocular conditions and obscure cases of optic neuritis after relief of nasal sinus disease, usually found due to nasal obstruction.

Now while it must be granted that the late results of deformed jaws interest mainly the specialist, this in no way relieves the general practitioner from initial responsibility in the matter. This facial deformity begins in children at the time of dentition, when they are under the observation of the family doctor. Frequently *he* is the man who takes out a first tooth that should be left to keep a place for the corresponding permanent tooth, and still worse, it is he again who removes a tooth in a crowded arch which needs, not opportunity to contract, but expansion. His responsibility is heavier, because the diagnosis of the condition is so obvious. A layman, innocent of medical training, can after seeing a half dozen cases, pick out at a glance the contracted upper jaws. No rhinological mirrors or apparatus other than a fair eye and a little common sense are required. The whole story is told by a look at the roof of the mouth. This does not of course reveal the nasal, aural, or ocular conditions, but one of my points is that the tooth deformity, regardless of its results, is in itself indication for treatment. From a cosmetic standpoint alone, deformed jaws deserve correction.

Quite as illuminating as the recognition of this deformity, is the discovery that it can be cured. Two methods of treatment have ardent supporters. The followers of Dr. Brown, who adopted an apparatus for the rapid separation of maxillæ, claim that only by this method can results be obtained. Dr. Brown believes that he separates the bones for their whole length along the intermaxillary suture, and that he tilts the teeth out and actually lowers the arch. He gets complete relief in ten days. Of course this procedure is just that which practitioners of orthodontia are taught to avoid, and naturally there are those who claim that it is both needless and undesirable.

This other school holds that adequate widening may be effected without either tilting the teeth or separating the suture. Foster presented models showing an increase of distance thus gained between the inferior turbinals of three to four and one-half millimeters. Both schools claim to get results in adults as well as children. There is reason to believe that either method is better than neglect. It seems sensible, and is demonstrated by experience that the earlier the mouth is perfected, the more normal is its development, and the more effective the treatment. Surprising results have been obtained, however, in cases up to forty years old.

This work which I have so imperfectly outlined, accomplished within a few years, has given practical bearing to knowledge that we have long possessed. It has shown more emphatically the importance of orthodontia, by demonstrating that many varied diseases have their origin in faulty dentition. It has shown how criminal is the indis-

criminate extraction of teeth, even when apparently useless or unsound; and it has taught us to seek nearer the source for the true cause of many apparently unrelated diseases.

From the foregoing we can fairly conclude that imperfect development of the upper jaw is the important factor in a large number of diseases, that diagnosis of the condition is easy, and that both methods of treatment are remarkably effective at all stages of the trouble.

Dr. Allen:—I think we are very fortunate in having as clear an exposition on the subject of which Dr. Beach's paper treats, as he has given us. I have recently heard in Philadelphia by some of the leading dentists, papers covering the same ground as that covered in Dr. Beach's paper, and stating some of the same facts, and I will admit that some of them were new to me, and I think we are very fortunate in having Dr. Beach's paper here this morning. He has grasped the situation very easily and made it very plain to us all by his graphic descriptions. There has been in the past considerable difference of opinion about the causation of the high arched palate. I think it is only fair to state that the opinion which is now pretty generally held that adenoids and tonsil hypertrophy caused by misplaced teeth is not universally agreed upon, but is largely a matter of theory and opinion and that a reasonable view also is that any nasal obstruction may reasonably result in high arched palate also. I think the opinion is as Dr. Beach has stated, that a large part of the tonsil and adenoid difficulty comes from the teeth originally. The impression which I get particularly from the papers which I heard in Philadelphia, was to the effect that this condition could not be looked after too early. That to let a child drift along until it gets to be fifteen or sixteen years old without attempting to correct the deformity, is a mistake and that a dentist should have an opportunity to correct a deformity of this kind and help out the difficulty as soon as it is manifested.

Dr. Sturgis:—I would like to ask Dr. Beach if there has been any question as to the muscular effect in cases of this kind—that is, in cases of the high arched palate.

Dr. Beach:—I have not had the opportunity to read anything directly on that line. Perhaps Dr. Allen could help us out some on that point.

Dr. Allen:—I remember a discussion in the Dental Association some years ago where there was a good deal of talk about affecting the muscles and making pressure artificially—perhaps pushing the teeth into certain positions. In my mind this is too superficial a cause to act very effectively in producing a deformity.

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CANCER.

BY DR. DONALD CRAGIN OF WATERVERILLE.

Read before the Maine Medical Association, June, 1912.

Mr. President and Members of the Maine Medical Association:—

The subject "Cancer" is as old as the oldest medical history. As a disease, it ranks in importance, as regards frequency and dire effects, with our worst scourges. Much time, energy and money has been and is being spent in research, and yet we are imbued with a feeling of helplessness as to the hope of cure when we are called to treat a case which has made any progression.

The pitiful inadequacy of our resources is never more keenly felt than when a patient presents himself and begs for cure. Realizing the horror of the late stages, as only one can who has watched the slow progress of many cases, no wonder the physician dreads the assumption of responsibility and anxiously casts about for aid from clinic and laboratory. But thus far the response has been practically negative. The patient, grasping at any chance of succor, naturally falls into the hands of the charlatan and quack, who promises much and performs little.

Being face to face with a superior enemy, we can at least put up a good fight, and make the most of our scanty munitions. We can systemize our defence.

In this paper I shall touch lightly, if at all, on the older portions of etiology, diagnosis and treatment as they are familiar to you all, but shall endeavor to talk mostly on the recent progress, taking that part which seems to have the most practical importance.

An immense amount of data has been collected during the past year and societies for cancer research are becoming active, particularly in Germany, Austria, Denmark and Chili. Newspaper information collected from reliable sources and presented in a manner which will impress the average reader, is one of the most effective ways of reaching the general public. This information should consist of an announcement in the daily papers of the country of the curability of cancer, if taken in time; the importance of early consultation with a physician on the advent of the slightest untoward symptoms; calming fears of operative interference; exposure of quackery; the non-contagiousness of the disease and so forth.

Let us consider about what available material we have at the present time. First, from the etiological standpoint. Coley, in a report from personal observavtion, bears strongly on trauma as an etiological factor. In 970 cases of sarcoma, 225, or 23%, had a definite history of preceding trauma, one of which were developed with-

in a month after the injury. In 250 cases of carcinoma, 33% had a history of injury, 120 were breast carcinomata, and of these 43% showed trauma as a factor. In carcinoma of the cervix, I think it is the common experience of us all to find a preceding laceration. True instances of cancer of the cervix in virgins is very rare.

The parasitic theory of cancer still holds attention and must be given due consideration. Leopold of Dresden and his assistant, Rosenthal, in 1896, described cells in carcinomatous tissue which showed independent amoeboid movement. Working on this up to the time of his death, he was not able by improvement in his technique to demonstrate this blastomycete in all cases, but in four cases obtained them in pure culture, sub-cultured them, and in three cases produced malignant tumors in rats by the injection of the cultures. What this may lead to is still a matter of conjecture, but the constancy of the presence of blastomycetes thus proven cannot be disregarded.

An exhaustive study of the vital statistics of cancer by Werner show that there is no etiological factor in geologic, hydrographic or climatic conditions. Reliable statistics show that carcinoma is on the increase. This cannot be accounted for wholly by increased diagnostic skill, for barring the internal forms, most laymen can diagnose late stages of cancer. The increase is limited to persons over fifty-five years of age. Cancer of the digestive system seems to be increasing.

Doyen's micrococcus neoformans has not held its place in the etiology though it is being commercialized and used as vaccine with varying effect in the treatment.

We are all familiar with the sex, race and age influence and the development of cancer on embryological tissue, which I shall not discuss.

The second subject for consideration in our forces is diagnosis. It cannot be too strongly or persistently brought before the people that the only safety at present lies in the early and positive diagnosis of cancer. A bewildering array of tests are at present offered for our consideration. They embrace nearly all branches of science and nearly all parts of the body either in normal or pathological state. I have been unable to find one which I can recommend on account of its infallibility and simplicity, one which the general practitioner can use. It is true, however, that in the hands of trained investigators, there is much to hope for in the future of these reactions as some seem to be based on rational grounds.

The serological tests seem to have rather the lead at present. I have been particularly impressed in regard to the action of the serum on pregnant women up to the tenth lunar month, of cancer cells. There

is evidently a carcinolytic property up to this time, whereas during this time the foetal blood as taken from the umbilical cord has no cytolytic power. This seems to prove the placenta as the transforming agent. I shall touch on this later in regard to treatment.

About the only thing we can rely on is the microscope, and here I enter a plea for the more frequent use of this instrument in diagnosis. Routine examination of curettings and suspicious tumors or ulcers save many lives. We have plenty of men in the State capable of examining pathological specimens, and I hope to see the State laboratory take this matter up and start a department for examination of tissue of those who cannot afford to pay the pathologist.

Cachexia, pain and tumor are always late symptoms and frequently indicate non-operability.

Treatment: "Two forms, curative and palliative. I lay myself open to criticism, but I firmly believe that the curative treatment is strictly surgical and the palliative surgical or non-operative. Granted that X-ray, radium, thorium, cancer-pastes, may cure slight epithelial growths, yet surgery can do better in a shorter time as the malignant tissue is removed at once and all danger of metastases stops. A month or six months of their treatment may be fatal to the patient. Physical agents and chemicals cannot touch the lymphatics. The actual accomplishment of cures in ascetic fluids, emulsions, neoformans vaccine and eosin-selenium combinations, treatment has yet to be shown.

Schmidt with an ingenious theory originated a vaccine treatment made from a parasite belonging to a class of the mycetozoa while in the saprophytic form called antimeristem on the principle of active immunization without local reaction, thus differing from Coley's serum. It can be used as a prophylactic or as a curative agent. He reports three cures, one of which was assisted by surgery. In the hands of other men, results have not been so satisfactory. It cannot yet be considered practical.

Fischera, an Italian, has done some remarkable experiments grounded on the following theory: that all carcinoma and sarcoma is a rapid proliferation of the embryonic type of cells. Arguing from the fact that an extract of a normal organ injected into a healthy animal causes destruction of the same organ, he took two to six months, human embryos, dissolved by autolysis after crushing, and then injected the solution into a patient suffering from cancer. He was very careful to have his diagnosis confirmed clinically and microscopically, and cured five patients. The most interesting point was the fact that the glandular involvement disappeared first. This treatment in connection with the experiments of Krauss and Graff on the serum of pregnant women furnishes much food for thought.

Concerning the operation for cancer, I could present numerous statistics to prove that the only chance is early and radical operation. In many cases of inoperable cancers, the patient is wholly responsible but the practitioner has to assume the responsibility never-the-less. Patients are constantly presenting themselves in late stages of carcinoma in the uterus and breast. Here is where publicity can get in its heaviest work. "Educate the people," is the slogan. The surgeon is only to blame when he hesitates to make ugly and radical scars in early stages. He must have courage and firm faith to do this, and by all means must tell his patient truly what he expects from the operation and what not to expect.

Much can be done surgically in palliation, though these operations are usually considered a failure by the patient's friends. Ample cauterization and curettage will produce wonders at times, reducing pain and discharge.

As regards palliative measures other than surgical, I can truly say that I have seen in several cases marked relief from pain and discharge by the use of trypsin injection though it had no influence on growth. Permanganate of potassium in lotion or wet packs is agreeable and comfortable. Radium and X-ray control pain for a long time. Radium tubes are very efficacious in reducing pain and discharge in inoperative cancer of the uterus, but no less than ten cg. should be used. This is beyond the pocket of most of us. Injection into the tumor of fifty to seventy per cent alcohol with one per cent hydrochloric acid retards the growth and relieves pain.

This then is about the strength of our battle line at present. I have said nothing concerning the biological work being done on cancer because I fail to see where it is yet of value to the general practitioner, though it promises something.

We await with longing an epoch making discovery. Until then, a paper on cancer smacks of the reiterative and commonplace. Yet so much can be done with our present knowledge in the relief of this dread disease that

Let us then be up and doing
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.

Dr. Gordon:—This is the same old chestnut that we have been trying to crack for years. We think we have discovered a cure for cancer and it appears to work in a few cases and then we find that it is not working and we cast about once more for something new, and the matter each time narrows itself down to the same old queries and answers. The great trouble in a good many cases of cancer of the uterus the women almost never attend to it at the proper time. They have perhaps been taught to believe that the menopause accounts for all these feelings and sufferings, and so they are disposed to put everything off expecting it to come right in time of its own accord. They think

everything abnormal is due to the menopause and so these things are left to develop into all sorts of trouble. When we have arrived at the point of better education of the women along this line, we shall have accomplished a good deal. When they get to the point where when anything out of the ordinary occurs they immediately consult a physician, they will have taken a long step in the right direction, for that is where very much of the difficulty lies, and about seventy-five per cent of the cases of cancer of the uterus will be cured by operation because it is easily discovered and as a rule it can be easily operated upon. I feel the same way about cancer of the lip and cancer of the liver, although the latter is harder to get at of course, but I think if the people who are afflicted with cancer in any manner would consult a physician at once, as soon as they have themselves discovered the difficulty, that very many of the cases that are eventually lost, might be saved. John Burns did more in his day and generation for cancer than has been done by any other man; his work has certainly been a step in the right direction.

Dr. Powers:—I cannot hope to add much to what Dr. Gordon has already said on this subject, but there has been one suggestion made by Dr. Cragin that impressed me and that was that he suggested that we have an opportunity of sending specimens to the State library. I believe that a large amount of the error that exists in the hands of the general practitioner comes from carelessly passing over questionable cases. We are too apt to make a diagnosis and call the trouble something else without taking all the means possible of confirming our judgment. We all see these cases constantly, time and again and it is up to us to take precaution to diagnose them with all care. In referring to the uterus cases and the cases more in evidence, if the women at the first sign of this trouble would consult a physician and if the physician would make a careful examination for just this trouble, we might in many cases save a great deal of needless suffering and physical danger later on. It is not an unusual thing for physicians to make mistakes in their diagnosis, but if the patient would upon the first sign of trouble consult a physician, many cases might be saved and many might be greatly relieved. It would save a great amount of physical suffering if cancer cases were not allowed to drift along so long without any treatment whatever, as is the case so often with tuberculosis. People dread to go to a physician, or else they seem to think that the symptoms are caused by the menopause, as Dr. Gordon has suggested, and so they simply drift along waiting to see what is going to be the outcome until the growth has reached a malignant form when practically nothing can be done, other than to give what temporary relief may be possible.

President:—If there are no further remarks, the paper now returns to Dr. Cragin.

Dr. Cragin:—I don't know that I can add anything to what I have already said other than to emphasize a little more fully this matter of publication. In Denmark, they have done some really remarkable work in this manner, that is by collecting from all reliable sources such information as will prove helpful to the public, and publishing it in the newspapers in a manner that will impress the general reader. It seems to me that this is one of the most effective ways of reaching and educating the general public, and these are the people we have got to reach, in order to do effective work in stamping out this dread disease. In Denmark, it is claimed that this has been the means of saving a great many women because they simply read for themselves that the beginning of cancer, the first symptoms are so and so, and that if taken in the beginning it is curable, and the people read these articles and then consult their physicians and surgeons and immediately get some chance of relief. They have done splendid work along that line and I believe we ought to do something of the same kind here in this State. I am more impressed with this idea the more I study it.

Necrology.

DANIEL WILLIAM HAYES.

Dr. Hayes, a member of the Maine Medical Association, of the Penobscot County Medical Association and of the American Medical Association, was instantly killed near Onawa Station, Maine, by a rear end railroad accident on the Canadian Pacific Railway, January 21, 1913. Dr. Hayes was born April 21, 1870 at Foxcroft, Maine, the third son of William and Mary Barrow Hayes, obtained an excellent education in the common schools of the town and at Foxcroft Academy, and whilst teaching during vacations, he paid his way through the three legal years of the Medical School of Maine, and was graduated there as physician and surgeon in 1897. He served a year as interne at the Maine General Hospital, and then another year at the Insane Hospital in Augusta. In the following year, he married Miss Lillian Parmenter of Albion, Maine, daughter of John and Maria Stinson Parmenter of that town. Dr. Hayes practised awhile at Foxcroft and then obtaining the position of surgeon on the Canadian Pacific Railway, removed his headquarters to Brownville Junction, where he spent most of his time when not travelling along the railway on railway illnesses and surgery. He died in the harness as is the term employed by writers of those who work to the last moment of their lives at their chosen profession.

Dr. Hayes as a child developed a kindly and lovable disposition which clung to him through life and he was admired by his patients and held in high esteem by his rivals in the profession. He is survived by a sorrowing widow and five children. Deeply religious, also, Dr. Hayes stood high in the community and was also known as a Mason of high degree and given to good works wherever he abode.

J. A. S.

JOHN MORSE WAKEFIELD.

Dr. Wakefield died suddenly February 27, 1913 at his home in Warren, where he had practiced most successfully for many years. The son of Ezekiel and Mary Morse Wakefield, he was born in Lewiston, December 9, 1853, and educated in the public schools, as well as at the Maine Seminary at Lewiston. He then attended the Portland School for Medical Instruction, and was graduated Doctor of Medicine at the Dartmouth College Medical School in 1874. Dur-

ing this educational period, he earned money by teaching and by saw-mill work to carry him through to his aim. He went to New York for a post graduate course in 1874-5 and then at once on his return from the metropolis settled in Warren where he practiced steadily and most faithfully and earnestly for thirty-eight years. He was what may be called a tremendous worker and seems during most of his life to have taken but one vacation and that to California. As a matter of course such energetic wastefulness of his body undermined his splendid constitution and he was attacked with Bright's disease. This he fought off as well as he could, but never recovered from its ravages. He worked to the last day of his life up to nine o'clock in the night; then fell unconscious and died early the next morning.

Dr. Wakefield was a personality in the region in which he lived and worked, a leader in medicine and a man of whom all were proud as physician and friend.

He married May 9, 1873, Miss Flora Emerson of Lewiston, who survives him as companion, counsellor and aid in life.

Dr. Wakefield was fond of horses and dogs, often owned as many as seven horses and declared that he would rather have them all chloroformed at his death rather than to think that they should ever be ill treated when he was no longer driving them to and fro on his long country rounds. He was a thinker rather than a talker, yet his genial presence amidst the sick was as good as much talk from other men. He was noted for a warm and sympathetic voice and a dignified demeanor wherever he went to his work. He served as President of the Knox County Society and was active in the work of our association.

J. A. S.

NOTICE.

A committee appointed from the American Association of Progressive Medicine (non-sectarian) to report on cancer at the annual meeting, next September in Poughkeepsie, N. Y., would be very glad to receive facts observed relative to any case of cancer, permanently cured of cancer.

Especially is it desired to know the conditions of treatment other than local treatment of the growth. Provided the case of cancer is permanently cured after a reasonable time (state time) without further treatment, any reasonable inference relative to cause or any logical conclusion relative to treatment will be appreciated and made to serve some good.

Address W. G. Jefferson, M. D., Chairman,

346 Cumberland Ave., Portland, Me.

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Editorial Comment.

Membership in the American Medical Association.

THE PROPOSED CHANGE IN NAME.

GEORGE H. SIMMONS, M. D., LL. D., CHICAGO.

Explanatory Note:—This abstract of an address before the Conference of State Secretaries is republished from the American Medical Association Bulletin of Nov. 15, 1912, on the request of the Judicial Council. The House of Delegates referred the report of the committee to formulate amendments to the Constitution and By-Laws to extend membership, presented at the 1912 session (Journal, June 15, 1912, p. 1899) to the Judicial Council with power to confer with constituent associations. The council, after careful consideration, endorses the proposed change and takes this means of bringing the subject to the constituent associations as well as directing to it the attention of the members.

I have been asked to discuss the present conditions of membership in the American Medical Association and the proposed change, which has been under discussion recently. While this is not directly related to the object of this conference, the discussion of uniform regulation of State membership, it is so closely connected with it that I cannot refuse to take advantage of the opportunity of discussing the question before such a large representation of State secretaries.

To get a clear understanding of what the present term "members" of the American Medical Association means, it is necessary to go back a little in the history of the Association.

The American Medical Association always has been a delegated body; only "delegates" ever had a right to take part in its proceedings.

"Permanent members" was a term originally applied to those delegates who connected themselves permanently with the Association after they had served as delegates. "Permanent members," however, had no rights except those of attending the meetings and taking part in the scientific work. In 1883, the Journal was started and the following year, for the purpose of increasing the circulation of the Journal, there was created another class: "Members by Application." A member of any so-called affiliated society could become a "member by application" simply by making application for membership and paying the annual dues. The difference between "members by application" and "permanent members" was that the latter had been delegates, whereas the former became members simply by making application. Neither "permanent members" nor "members by application" had vote or voice in business meetings.

**Membership in the A. M. A. Today on the Same Basis as the Former
"Members by Application."**

Briefly, we have the following situation:

1. The voting membership of the organization is the combined membership of all the 2,000 (more or less) component county societies, amounting approximately to 70,000 members. These elect the delegates to the House of Delegates of the State associations; they in turn elect the delegates who form the House of Delegates of the American Medical Association. Before 1901 the delegates to the American Medical Association were elected, or appointed, by the "affiliated" societies, which included local, district and State societies. Since 1901, that is, since the reorganization, the delegates to the national body are elected not by local, district and State societies, but by the State societies alone.

2. The so-called "members of the American Medical Association" are the direct successors of the old "members by application." By their payment of dues and their subscriptions to the Journal, they were and are today the supporting or contributing group of the members of the organization.

3. The House of Delegates is composed of approximately 150 members, who are elected by the various States Houses of Delegates, which are in turn composed of delegates elected by the members of the component county societies. The House of Delegates of the American Medical Association, therefore, is created by, and represents the combined membership of all the county societies of all the States; it is not elected by, nor does it represent, the present "members of the American Medical Association" as such; it never has.

The result is that we have two classes which could be called members. First, the actual, logical memberships of 70,000, usually desig-

nated as "the membership of the organization." Second, the 36,822 contributing or supporting members, who are designated as "members," although these "members of the American Medical Association" have no more privileges than have all members of the organization, except the right to take part in section work. This present situation I have had shown on the accompanying chart (Chart 1). The membership of the American Medical Association, at present 36,822, is an inner circle of the membership of county societies, while the House of Delegates is a still smaller circle composed of those who have been elected to represent the members of the organization of the whole country.

The Present Situation



Chart 1

Now the situation itself is perfectly logical and is in every way to be commended. The trouble is that we have not named our groups accurately. Those whom we now call "members of the American

Medical Association" are really those members of the organization who, in addition to supporting their county and State associations, also contribute to the support of the American Medical Association, while for the actual membership of 70,000 members we have no distinctive name.

The change that has been proposed is not a change in condition at all. It is simply a change in name. It is proposed to designate the 70,000 members included in the large outer circle (Chart 2) as "mem-

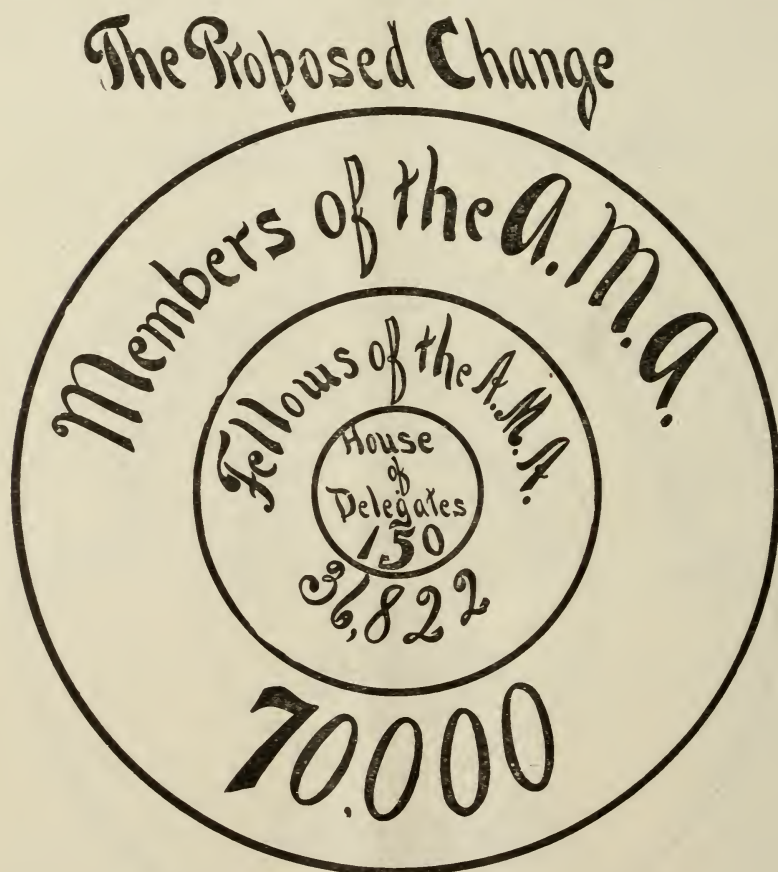


Chart 2

bers of the American Medical Association," which they really are and always have been, while those included in the inner circle (that is, those members in good standing of their county and State societies, who also pay \$5 a year to support the work of the American Medical Association) are to be called "fellows of the American Medical As-

sociation" instead of "members." This will make no change in the membership standing or relations of any man. If this suggestion is adopted, all members in good standing in their State organizations will be designated as "members of the American Medical Association," while those members who contribute \$5 a year to support the work of the Association will be designated as "fellows of the American Medical Association." In other words, those who are now known as "members" of the American Medical Association will be known as "fellows" of the American Medical Association, while the term "members" will be applied to the entire, combined membership of the component county societies of the whole country.

This plan has several advantages. In the first place it will give us a name for the entire membership of the organization, which we have never had before. Before 1901, they were referred to as members of "affiliated" societies, and since then they have been called, for lack of a distinctive name, "members of the organization." Another advantage will be that it will make clear that the voting power lies with the 70,000 members and not with the 36,822 "fellows." When this plan was first proposed, some got the impression that the intention was to compel the 70,000 members of the county societies to become "supporting members" of the American Medical Association, as the term is now understood. This, of course, would be a ridiculous proposition. The proposed change contemplates leaving membership conditions exactly as they are; it contemplates changing the name, and not the relation.

One great disadvantage prior to the reorganization of the American Medical Association in 1901 was the fact that we had no name by which to designate the delegates. As soon as the name "House of Delegates" was adopted, then the function of the delegates became clear at once. The Association also has labored under the disadvantage, ever since its reorganization, that there has been no name by which to designate the actual voting membership, because the term "members" had been applied to the supporting body. The proposed change simply recognizes this fact, designating as "members" those who really are members, and designating the supporting members as "fellows."

I have already given some reasons for making the change, but there is another and more important; in fact, it is the paramount reason. Up to the present time, the members of the organization have not realized that they are, in reality, members of the American Medical Association. They regard the American Medical Association as something entirely apart from them, something in which they have no interest. These members of the organization are through their

elected representatives responsible for what the American Medical Association is doing, or what it ought to do and is not doing, but they do not realize this, hence they are not interested. They do not appreciate that the House of Delegates of the American Medical Association, which they elect, is the body that is doing the work through the officers, trustees, councils, etc., which they, through their representatives in the House of Delegates of the American Medical Association, select. While only a change in name, I think the subject is of the utmost importance. I hope that all of you will look into it carefully, so as to understand exactly what is intended, and then will explain it to your members at the first opportunity.

A Medical Status for Chiropody.

I am glad to observe that my often expressed desire to have chiropody practised by educated physicians has at last obtained some recognition. Too long has this important branch of minor surgery been carried on by ignoramuses. The State of New York has now decreed that the State Board of Medical Examiners shall determine the fitness of chiropodists, and that candidates for a license to practice this branch of surgery must be graduated from a school of chiropody, registered by the State Regents as supplying a proper standard for preparation and fitness to carry on the work. A new school has been established, and as the faculty are physicians in good standing the public will benefit in due season. For years, to be "a corn doctor" has meant nothing more than to be a mere scraper off of corns and plasterer up of bunions. Henceforth, we shall literally march on sounder feet in the path of medical progress.

J. A. S.

Is the Present American Agitation Concerning Trachoma Based on a True Scientific Knowledge of the Disease?

A recent number of the "Wochenschrift fuer Therapie des Auges" ("Weekly Journal for Treatment of Diseases of the Eye," etc.), expresses the opinion that an enormous number of actual cases of follicular conjunctivitis are in America entitled erroneously trachoma. Yet all scientific ophthalmologists ought to know that the anatomical and pathological differences between the two diseases are easy to discern and are distinctive. The Germans believe that owing to this ignorance on the part of American health officers, many emigrants are being returned improperly, to their starting places in Europe. The Germans are wondering when Americans will understand that follicular conjunctivitis is not trachoma at all, never degenerates into

trachoma, and is not a dangerous or contagious affection in any way, shape or manner. It might be wise on the part of the Portland health inspectors to exhibit to the skilled ophthalmic surgeons of this city and State, some of their next trachomatous emigrants with a view to determine whether the German scientists are building their assertions upon the firm foundation of microscopic truth.

J. A. S.

Worthlessness of Patent Medicines. An English Investigation of Today.

A select parliamentary committee is now investigating in England the composition of patent medicines with a view to discovering the various drugs employed, and especially the amounts of opium included in those most prominent before the public. A most amusing interview took place with Sir Joseph Beacham as a witness. His father, as is well known, invented the pills which have made the name famous and himself rich, and the son has obtained by this money a baronetcy because of his charitable gifts. The Honorable Baronet testified that he sold his pills by the ton, spent approximately half a million in advertising, and obtained an income of about a million and a half a year. The firm also makes and sells a cough pill, which sells equally well with the famous laxatives by the same name. When the committee inquired regarding the amount of opium in the cough pills (contrary to the laws for dispensing opium in any shape without a physician's prescription) the baronet granted that all the opium formerly used in the cough pills had now been omitted, but that they seemed, according to all reports, to relieve spells of coughing just as well as ever.

J. A. S.

The Sun Eclipse in Germany as Reflected by Injuries to the Retina.

The eclipse of the moon, set forth for Friday the 21st of March, 1913, reminds the writer of this notice, that the eclipse of the sun which was total in Germany in 1912 was followed by numerous instances of temporary blindness in persons so thoughtless as to look at the sun without protecting lenses of some sort. One German Ophthalmological Journal reported seven cases of scotomata and contractions of the field of vision, and that report has been followed by several others, so that the number of patients seriously injured, for all time, must number nearly one hundred. The ophthalmoscope revealed a grayish opacification in the retina, and the symptoms varied from total loss of sight at first, to a partial recovery with defects remaining in the field of vision. Although such eclipses are rare, the

ophthalmic surgeons throughout the kingdom of Germany are urging instruction of the children and of the people generally, to the need of invariably wearing amber, or luxfell-tinted protecting lenses, whenever an eclipse as predicted by the astronomers, arrives. J. A. S.

Motor Car Tags from an Oculist's Standpoint.

It seemed to me, last summer, proper to call public attention to defects on motor car tags. The limbs of the letters and figures were so thin that they could not be seen, even on a clean tag, more than one hundred feet. The letters and figures were also so closely pressed together, that many could not be identified at seventy-five feet. The letter B was so defective without its two distinctive backward projections, that at a short distance it could not be distinguished from an 8. The result of this especial defect was, that owners of cars with a tag beginning with the figure 8 were liable to arrest for offences committed by drivers of cars labelled with B and a number. The result of all these defects, to say nothing of the poor contrast, purple on yellow, was that proper identification of cars was difficult for those who believe that pedestrians have a right to protection from reckless speeding. I also showed that even when a tag was clean, and hardly one is ever clean for more than an hour, any car could in two seconds be so far away as to escape recognition of the number on its tag.

The tags for 1913 are again defective in many ways. The limbs of some figures and letters are wide enough, those of others are too thin. All of the figures and letters are still disproportionally high to their width. The spacing is good on some tags and bad on others. The B is as obscure as it was before, and the contrast, reversed from last year, is just as defective as ever before.

The absolute defect of every tag so far shown for 1914 is that not a single letter or figure has been drawn upon a STANDARD OF VISIBILITY. Figures or letters to be seen at say 180 feet (the distance which a car can run away from perception of its tag number in three seconds) they must occupy a standardized portion of an imaginary space 3 and $\frac{7}{16}$ inches square. The limbs must measure $\frac{1}{16}$ of an inch at every part.

It is useless in this paper to go into details, but the motor men of Maine and the Secretary of State should be compelled to call in expert opinion and obtain a STANDARD set of figures and letters to be painted on the only proper contrast, WHITE on BLACK.

The scandalous defect in the use of tags, is that owners can place them where they please, front or rear. Front tags are mostly placed on the axle where they may be hidden by the handle of the crank, or dusted or mudded out of visibility in a few minutes. Rear

tags are likewise placed largely upon the axle, many on the side away from the lamp, and very few close to the lamp as they ought to be. I defy anybody to recognize at night by its rear tag, one car out of fifty in Maine. A fine of \$5 for every day that a tag appeared placed in such a position as on the axle or on the side away from the rear lamp would bring most owners and drivers to a sense of the rights of pedestrians. New legislation having all gone in to the Legislature, it looks now as if we should have to wait two years more for STANDARD TAGS PROPERLY PLACED ON OUR MAINE MOTOR CARS AND TRUCKS.

J. A. S.

Friedman Cure.

At the November meeting of the Berlin Medical Society, Dr. Friedman read a paper entitled "Curative and Preventive Vaccination in Human Tuberculosis." He reviewed the work of Koch and others along the line of vaccine therapy in tuberculosis.

He maintains that all preparations now used are made from highly toxic and virulent culture of bovine or human tuberculosis and killed. He has sought to find a remedy which should possess all the possible specific properties of the germ outside of its toxicity and virulency and which should be harmless even in large doses, when the live culture is injected.

He contends that he has found, in a strain of avirulent tubercle bacilli, which he had secured several years ago, the solution of the whole problem. By proper transplantation and passage through animals, he has secured a non-virulent culture and at time of writing had treated 1,012 patients. The treatment consists of intra-muscular injections, repeated at long intervals, once, twice, thrice; seldom more. In some cases, the intravenous injection is necessary to obtain results.

The paper reviews his experimental work and the discussion revealed some few members who spoke of very favorable results with the use of the remedy while a few failed to secure any results. The concensus of opinion is that in the avirulent strain of Friedman's, we have great promise but the question naturally arises will it remain avirulent and what about contamination? Dr. Friedman insists that the culture is avirulent by nature and can not become virulent but will not state how he produces this result.

It was pointed out that Pasteur lived to see a failure of his chicken cholera vaccination, which was successful at first but later gave rise to severe epidemics because for some unknown reason the avirulent virus became virulent.

It is unfortunate that this matter should receive such publicity through the lay-press while the medical profession is constantly appealed to as to the probability of results.

Medical Legislation.

Thus far during the Legislative session, there have been several matters before the various committees of interest to the medical profession.

MEDICAL REGISTRATION LAW.

There was a report from the Judiciary Committee of "ought not to pass" on the act strengthening our Medical Registration Law.

AN ACT FOR THE PREVENTION OF OBTAINING MEDICAL CHARITY BY FALSE REPRESENTATION.

The next bill of interest was an act which provided that any person fraudulently seeking charitable, medical or surgical service will be guilty of misdemeanor and subject to imprisonment or a fine. This was referred to the committee on legal affairs and a report from this committee was "Legislation inexpedient."

STATE BOARD OF CHARITIES.

The next bill of any consequence was the State Board of Charities and in this instance the act was submitted by the Committee on Appropriations who were honestly trying to solve this perplexing problem. This bill provided for a committee of three, of which one should be a woman, to serve without pay, while they in turn should appoint a specially trained man to act as an investigating officer and paid a fixed salary.

This would have helped matters pertaining to appropriations as well as to running of the various institutions.

There was also the so-called "Cole bill" introduced which provided for one man appointed by the Governor. This bill was destined merely to create another political berth and received little support. The report of both bills which came from the Judiciary Committee was "ought not to pass" but through the active efforts of the members of the Appropriation Committee, the first was recommitted to the Judiciary Committee and thus far no report has been made.

OSTEOPATHIC BILL.

The last bill of any consequence was the Osteopathic Bill. In Section 5 of the proposed act, "the new board shall have the power to grant a certificate which will entitle him to the right to practice osteopathy in any county in this State and shall confer upon the person all the rights and duties conferred by the law upon other medical practitioners, except the right to administer medicine internally and perform major surgery."

Whereas, in Section 4, we find among the qualifications for practice by osteopaths, "anatomy, physiology, chemistry, bacteriology, toxicology, pathology, dietetics, diagnosis, hygiene, obstetrics and gynecology, minor surgery, principles and practice of osteopathy."

The contention of the proponents of the bill was that they did not ask for recognition but only wanted protection and, furthermore, they did not ask to practice medicine, that is to say, they distinctively printed in their bill that they should not be allowed to give medicine internally.

There was some difficulty in obtaining a satisfactory definition of the practice of medicine, and yet we all know that in the text book on Practice, that an extremely small amount of space is devoted to giving medicine internally. On the other hand, we find nearly all the space given over to the etiology, pathology, diagnosis, prognosis, while under treatment the greater part of the space is devoted to hygienic measures. This book in itself represents the definition of the practice of medicine in as true a sense as the text book on surgery would define that subject. Moreover, our medical practice act, which is the legal instrument under which we all register to practice medicine and surgery is equally as comprehensive. The osteopaths suggested that they were willing to eliminate all surgery from the provisions of this act and yet the act provides that they shall do obstetrics and gynecology both of which require surgical training. In fact, the gynecologist of necessity must be a trained surgeon, while obstetrics is rapidly becoming more and more classed as surgical procedure and requires a man trained in surgery to meet the various complications as they rise so that were this bill allowed to become a law, it would confer on these men the right to do surgical work and at the same time exclude them from doing surgery. This would raise legal complications and ultimately result in giving them the free right to do surgery.

A little interesting phase of this hearing was the statement made that an osteopath had applied for an examination before the registration board and had been refused. It is safe to assert that this same osteopath would be refused the rights of examination from the board they are desirous to create as there are a very few osteopaths in the State of Maine who have devoted three years of nine months or four years of eight months and surely a very few if any have covered the subjects enumerated in the requirements of this bill. On the other hand, any school or college which requires so complete and thorough a course in the above mentioned subjects is in fact a medical school whether it is designated osteopathic, homeopathic, eclectic or any thing else, and the graduates of such a school having devoted four years of eight months would have the right to appear before our

Board for the regular examination so that the necessity of the creation of a separate board is practically nil. On the other hand, another board would create considerable confusion and future legal competition.

If the osteopaths want protection, let them submit a bill giving a full definition of osteopathy as it is generally understood, namely **"A method of treating diseases of the human body, without the use of drugs, by means of manipulations applied to the various nerve centers, chiefly those along the spine, with a view of inducing free circulation of the blood and lymph, and an equal distribution of the nerve forces."*

"It teaches neither therapeutics, materia medica, surgery nor bacteriology but rests entirely upon the manipulation of the body for the cure of disease."

If they will moreover incorporate in such a bill, a provision making it impossible for some group or groups to approach every succeeding legislature for an extension of these rights, they would find very little opposition. This matter is not nearly so important to the medical profession as to the public and yet as custodians of the public health, we should all take active interest.

This bill was reported by the Judiciary Committee as "ought to pass" in a new draft by a majority and minority report. On Wednesday, the 26th of March, the matter came up for discussion in the senate and the minority was accepted, thus disposing of the matter in the Senate. It will now go before the House and every physician who is interested in the welfare of the State has no hesitation in his mind as to the result in the House, as any fair minded man, knowing the true facts of the case would certainly use their influence in this measure.

A significant fact was the total absence of any members of the State Board of Registration. Whether from lack of interest or not, it is impossible to say, but it was surely a matter of more interest to them than the majority of those who attended the hearing.

It is about time the medical profession began to organize more closely and endeavor to bring about more harmonious work of the various medical organizations in the State.

*Annual Encyclopedia.

NOTICE.

Any member in good standing in the State Association, wishing to serve as a delegate to the meetings of other State Societies, should communicate with the President, Dr. R. H. Marsh, Guilford, at an early date.

Book Reviews.

The Medical Men and the Law.

In the preface, the author points out the necessity of the medical practitioners to have some knowledge of law. It asks "Can they vindicate their rights without reference to the numerous acts of the Legislature on which they are founded? Can they prove the guardians of the public health without knowing the enactments by which it is protected? Can they advise the legislative or executive power on numerous points submitted to their consideration without understanding the bearings of the question referred to them? Can they successfully suppress malpractice suits when they are ignorant of what the law requires of them in regard to the skill and care to be exercised?"

After a historical survey, it takes up the definitions of physicians, surgeons, specialists, etc.

In Chapter 2, it takes up first the constitutionality of statutes regulating the practice of medicine.

Second, the requirements for admission to practice.

Third, what constitutes practicing medicine or surgery.

Fourth, right of women to practice medicine.

Fifth, the right of corporations to practice medicine.

He goes on to take up the relation of physician to patient, compensation, malpractice or negligence, criminal liability of physicians and surgeons, exemptions of physicians and surgeons, physicians and surgeons as witnesses, the right to protect professional reputation, the validity of contract restricting exercise of profession, and finally wills.

This is a very interesting book and a valuable addition to any medical man's library.

Principles of Hygiene. (The new fourth edition.)

By D. H. Bergey, M. D., First Assistant Laboratory of Hygiene and Assistant Professor of Bacteriology, University of Pennsylvania. W. B. Saunders Company. Cloth, \$3.00 net.

This edition of the Principles of Hygiene should prove to be of great value to all who are interested in questions pertaining to health and its preservation.

There have been great advances in methods of prophylaxis as the knowledge of disease transmission is now quite extensive and of a reliable nature.

The chapters on Water and Water Supply and on the Removal and Disposal of Sewage contain the last word that science has evolved on these subjects. The book contains many other valuable points

which are of vital interest to all; personal hygiene, industrial hygiene, school hygiene, military and naval hygiene, each have a chapter.

Vital causes of disease, disinfection, quarantine and vital statistics are presented to the reader in a clear and concise manner.

The chapters on air, ventilation and heating assemble facts with which we are all more or less familiar, yet when thus collected are of interest and valuable for reference.

Food and dieting, exercise, clothing are subjects which while old are ever new; the pages devoted to these subjects contain many helpful hints.

The theory of immunity and susceptibility are handled in this work more clearly and concisely than in any other book it has been my fortune to read.

M. C. W.

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Review of Current Literature.

Journal American Medical Association, June 13, 1912.

Experimental Intestinal Obstruction in Dogs with Especial Reference to the Cause of Death and the Treatment by Large Amounts of Normal Saline Solution.

By John A. Hartwell, M. D., and J. P. Haguët, M. D., of New York.

This paper describes some experimental work done upon dogs, with the object of determining the cause of death in intestinal obstruction. They applied a clamp to the duodenum under ether narcosis firm enough to obstruct the contents of the intestine but not the circulation.

The dogs died in from seven to ten days. At autopsy, there was more or less marked degeneration of kidney and liver cells often going on to actual necrosis, and the intestinal mucosa above obstruction showed an exfoliation of the lining cells, as well as an edema of the sub-mucosa.

These changes are similar to those formed in various toxic conditions including starvation.

Cultures were taken after death in four cases; the peritoneum femoral blood, liver and spleen, were all found sterile in every instance except one in which there had been a perforation.

It was thus proved that a bacterial invasion is not necessarily present in obstruction of the duodenum.

They found that these animals vomited large quantities, the amount of vomitus and urine for twenty-four hours was recorded, and normal saline solution slightly in excess of the amount of fluid lost be given daily in the form of hypodermoclysis, the dogs promptly return to the condition of a dog undergoing simple starvation. Dogs thus treated have lived in excellent health for periods of three weeks or more and showing at the end of that time that they would live much longer if the treatment was continued.

Their conclusions are that the cause of death in obstruction of the duodenum is probably due to the loss of water by vomiting.

A. H. W.

The American Journal of Medical Science, Dec., 1912.

Indicanuria.

By William Gerry Morgan, M. D.

Indican or the indaxyl sulphate of potassium is formed from indol and indol results from bacterial digestion or putrefaction of

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proteids. It is fairly certain that the lower part of the ileum is the chief laboratory for the formation of this end product and that the principal seat of absorption is the colon.

Since we have no means at present of determining the quantity of the more definitely poisonous tax albumins, we must estimate their amount by the degree of putrefaction; as shown by amount of indican in the urine, an excess of indol absorbed from the intestines, long continued is probably responsible for certain pathologic changes particularly in the blood vessels and kidneys. It is thought that this may be due to the indol stimu-

lating the adrenals to increased secretion.

All cases of intestinal putrefaction do not result in indicanuria, on the other hand indicanuria may result in cases where the degree of putrefaction is very slight, especially if there be a loss of continuity of the surface of the colon.

The writer during the year 1911, in the regular routine examination found indican either transitory or presistent in 148 cases.

He uses for routine test 10 c. c. HCl. 10 c. c. of a 1% solution of potassium chlorate three drops of which is added to the urine and shaken up with 5 c.c. of chloroform. The amount of indican is graded according to intensity of color from plus 1 or sky blue to plus 6, a very black blue. A study of the above cures show no etiological factor common to all or even to a considerable number of patients. Of 113 patients in which gastric analyses were made, 46 showed hyperacidity, 25 subacidity or absence of acid, 42 normal. Simple constipation does not seem to be a cause of indicanuria, obstructive constipation of the transverse colon or above usually results in a well marked indicanuria, obstructions lower down are not usually complicated by indicanuria.

Indican is increased in peritonitis, typhoid accumulation of pus, also after all operations in which the intestinal wall was cut or intestines roughly handled. The symptoms vary greatly in different cases, one of the most common was gas in the bowels, early fatigue, dull headache, languor, insomnia, cold extremities, etc., are among the more common.

The treatment should include measures to prevent the formation of toxins and elimination of these already formed. Purgatives do not cause a diminution of indican, but may be followed by an increase, irrigation is of benefit, reduction of the quantity of proteid food, frequent changes in the diet, general hygiene, and in cases where overwork is a factor, rest and a change of surroundings produce the best results.

A. H. W.

Pituritin in Amenorrhea.

By R. Hofstater.

Hofstater reports favorable results with its use in amenorrhea, hypoplastic uteri and undeveloped ovaries; also in atrophic uteri due to lactation, anemia, cachexia, etc.

In most cases a few injections gave the desired results.

The flow was normal and accompanied by the normal subjective symptoms.

In the obese patients he also gives thyroid extract.

M. C. W.

An Unusual Effect of Pitu.

By Rudolf Patek.

Patek has employed pitu in abortion cases where the cervix is well dilated but the pains are not sufficient to expel the debris. In most of his cases, it worked well, however in three cases, all of which were of four months duration and there was dilation sufficient to admit two fingers, he found after giving the pitu, a complete cessation of hemorrhage and contraction of the cervical canal. These cases had to be dilated instrumentally.

He does not believe that pitu would cause persistent enough contraction of the cervical canal to indicate its use in an attempt to carry a threatened abortion to full term.

M. C. W.

Experiences with Pituitary Gland Extract in Obstetrics.

By M. Eisenbach, November, 1912.

The author makes the following conclusions:

Variance of effect of extract due to inexactness of dosage and inequality of gland substance.

At present only means at hand that may be employed to stimulate uterine contractions.

Can influence favorably all cases of atomy provided sufficient doses are used.

Abortion can not be accomplished by this drug.

Especially useful in atonic hemorrhages.

No untoward effects following its use.

M. C. W.

New York Medical Journal, Jan. 4, 1913.

The Doctor's Future.

By Charles L. Dana, M. D., of New York.

The author first takes up the statistics in regard to the practice of medicine. He quotes from tables which show that in the last ten years the medical graduates have remained about the same, but that the medical students, medical colleges and physicians have decreased markedly. Nurses, midwives and druggists have increased by a large percentage.

He points out that the future of the medical profession will be along the lines of prophylaxis, hygiene and scientific progress in the face of all modern obstacles.

He says that in the times to come the hospitals will be used for the cure of the sick poor, and for teaching purposes, and that there will be a corps of social workers connected with all institutions for the purposes of investigating all cases for admission, to the end that hospital abuse may be lessened.

He says that the old family doctor was a nice old man, but ignorant and that he is well buried.

He speaks of the new type, the well trained internist, who makes a better doctor for the individual and the community. He mentions the absolute need of the technical skill of the special surgeon. He does not seem to think much of women as physicians, but admits that their place is in the laboratory or institution.

Doctors will have much more authority in the schools and in their influence upon marriage than is now the case.

Dr. Dana makes the wise observation that the doctor will have much power and will be much more concerned with public affairs relating to individual and public health than obtains now, and that those things pertaining to long and robust life will receive all the attention due them regardless of politics and commercial activities because it will be realized that public health is the great foundation upon which the accomplishments and successes of all nations rest. A very logical and interesting article.

HAROLD A. PINGREE.

County News.

CUMBERLAND.

PORTLAND MEDICAL CLUB.

The third regular meeting of the year was held at the Columbia Hotel on March 6th, with thirty members present.

The bill presented to the Legislature by the osteopaths was discussed and two delegates were appointed to attend the hearing at Augusta and oppose the passage of the measure.

Dr. Webster reported for the committee on Board of Health, and presented a set of resolutions, urging that the Mayor and Board of Aldermen appoint, in place of the former Board of Health, a health officer who shall devote his entire time to the directing of the public health work of the city of Portland. These resolutions were endorsed by the club, and it was voted that a copy be sent to the Mayor and each of the Board of Aldermen.

At the suggestion of Dr. Burr, a committee was appointed to see the officers of the United States service who are stationed in Portland, and invite them to participate in the meetings of the club.

Cases were reported of nutmeg poisoning in a pregnant woman, and of acetanilid poisoning from headache powders.

The paper of the evening was by Dr. W. Bean Moulton, his subject being "Extra-uterine Pregnancy." Especial emphasis was laid upon the necessity of early diagnosis, and immediate operations was advised in all cases. The paper was most instructive and interesting, and elicited a free discussion.

H. J. EVERETT,

Secretary Pro tempore.

AROOSTOOK.

The Aroostook County Medical Society has not been able to get together this winter on account of the poor railway service. Members from the southern part of the county, would have to take two days. The meeting was called in January but was postponed for this reason. We have been waiting for better service but just now it seems likely that we will not meet before our annual in June at Houlton.

W. G. CHAMBERLAIN, *Secretary.*

FRANKLIN.

At the invitation of the Franklin County Medical Society, Dr. Henry W. Miller of Augusta, gave a paper on "Eugenics," at the

State Normal School, on March 14th. The general public was invited and a good number were present. Dr. Miller's talk was extremely interesting. Several laymen expressed the opinion that more information in that direction given to the public would be of great value to the community.

G. L. PRATT, *Secretary*.

OXFORD.

The next regular meeting of Oxford County Medical Society will be held at Needham's Hotel (formerly Cobb's Hotel), Mechanic Falls, on Monday, March 31, at about 10.30 A. M.

Dr. Wallace E. Webber of Lewiston, will read a paper on "Minor Surgery." This paper and the free discussion which is sure to follow, ought to bring out many points of practical value.

Dr. E. S. Cummings, Councillor for this district, will be present, and Dr. J. A. Nile will present for the consideration of the society certain resolutions regarding Physician's Liability Insurance, Contract Practice, Medical Charities, etc.

Any remaining time will be used in the discussion of business affairs, collections and fees.

D. M. STEWART, *Secretary*.

YORK.

The 72nd quarterly session of the York County Medical Society will be held at the Webber Hospital, Biddeford, Thursday, April 3rd, beginning at 10 o'clock A. M. The Webber Hospital Association has invited the members of this Society to be the guests of the Association at a luncheon on that occasion.

An interesting program will be given and a large attendance is desired.

A. L. JONES, *Secretary*.

SURGICAL SUGGESTIONS.

The healing of a mastoid wound is often accelerated by lengthening the intervals between dressings, allowing Nature to do her part in repair with minimal disturbance. — *American Journal of Surgery*.

Persistence of suppuration after incision of a furuncle or abscess of the auditory canal or auricle indicates the development of a localized chondritis. — *American Journal of Surgery*.

Chronic suppuration in the middle ear may be entirely due to an adhesion near the floor of the tympanum and the internal wall forming a pocket in which pus may lodge. — *American Journal of Surgery*.

*Program of Maine Medical Association, June 25, 26, 1913.

Treatment Compound Fracture. (Symposium).

Conservative Treatment,	Hiram Hunt, Greenville
Radical Treatment,	W. C. Peters, Bangor
Radiography,	F. W. Lamb, Portland
Lateral Curvature,	E. G. Abbott, Portland
Thyroid, Distribution in State of Maine,	F. E. Leslie, Andover
Preventive Treatment Gonorrhea,	Wm. H. Wilson, Major Medical Corps, U. S. Army, Ft. McKinley
Annual Oration. Typhoid Fever,	David L. Edsall, Boston
Artificial-Pneumothorax,	F. J. Welch, Portland
(Subject not announced)	F. C. Tyson, Bangor
Latest Laboratory Tests which are of Value in Diagnosis,	F. N. Whittier, Brunswick

*The above represents the work of the Program Committee to date. The subjects, as given, were, in the main, suggested by the Committee and may later undergo change by the authors in the final program. The Committee is particularly anxious to hear from anyone who is doing any original work or interested in any particular lines and desirous of a place on the program.

Interesting case reports are always desirable. The Committee would appreciate suggestions from any member of the Association in regard to subjects to be introduced or authors who have valuable papers to submit. Communicate with Program Committee, 148 Park St., Portland, Me.

SURGICAL SUGGESTIONS.

Before terminating a mastoid operation, scrape clean the exposed bone surface. The wound will granulate more quickly. — *American Journal of Surgery*.

A "positive" blood culture in a case of otitic or mastoid disease is pathognomonic of sinus involvement and an absolute indication to tie off the internal jugular vein. — *American Journal of Surgery*.

Repeated aspiration of an ear discharge, the syringe tip or otoscope snugly fitting the external canal, greatly accelerates the cure of an otitis media. — *American Journal of Surgery*.

Personal News and Notes.

Dr. Frank Kilburn, President of the Aroostook County Medical Society had the misfortune to lose all his office fixtures and instruments in the fire of March 10. Afflictions never come singly, as the doctor was ill at his home with a sprained ankle.

Dr. A. Lomis Sawyer of Fort Fairfield has purchased a farm near the village, which he intends to oversee in connection with his practice.

Dr. L. A. Girard has been elected city physician of Biddeford, and Dr. Laura Black Stickney has been elected city physician of Saco for the present year by the incoming city governments which were inaugurated Monday, March 17th.

Dr. M. H. Ferguson of Biddeford left that city on March 21st for a two weeks' trip to the middle West.

Dr. J. A. La Pointe, the leading French physician and surgeon of Biddeford, died at his home, 24 Center Street, Sunday morning, about 6.30 o'clock, following an illness of about three weeks. Death was due to a paralytic shock.

Dr. John Clement Parker died at Providence, R. I., Wednesday evening, March 12, after a week's illness from pneumonia. He was a graduate from the Bowdoin Medical School and practiced medicine at Lebanon, Farmington, N. H., and at Providence, where he resided.

MAINE EYE AND EAR ASSOCIATION.

The Maine Eye and Ear Association held its first meeting of the year, February 7th, at the New Science Building, Bates College.

Prof. Whitehead of Bates College gave an illustrated lecture on the subject of the "Telephone."

Dr. C. E. Norton of Lewiston read a paper on "Telephone Deafness."

Dr. E. E. Holt, Jr., of Portland, Dr. C. E. Norton of Lewiston, and Dr. W. E. Whitney of Bangor are a committee of arrangements for the June meeting which will be held at Portland in connection with the Maine Medical Association meeting.

A. H. LITTLE,
Secretary.

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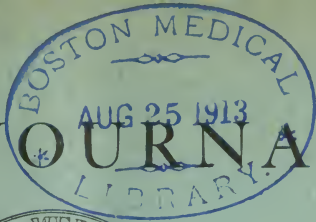
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MAY, 1913.

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The Maine Medical Library is available to members of the State Association. Write Miss Eileen Moore, 79 Bramhall St., for books and other data.

Members should notify the editor of any change in address, also notify him of failure to receive copy of the Journal.

Notice from members regarding sale of practice, merchandise, etc., should be sent in early and specify the number of insertions.

All news items, case reports, etc., must be had by the 15th, for insertion. Papers are published in order of their being received, with the exception of State papers which take precedence.

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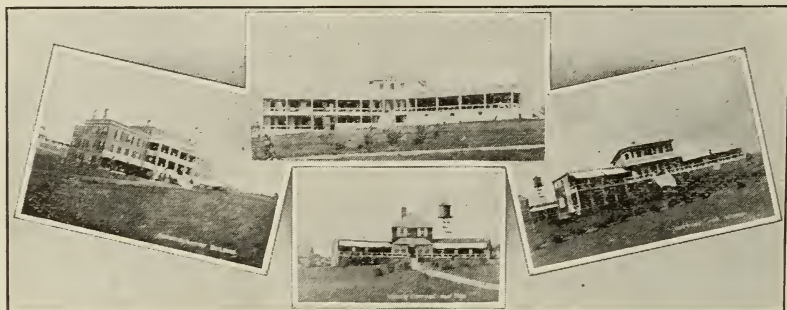
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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. III.

MAY, 1913.

No. 10

SYMPTOMATOLOGY AND CLINICAL TYPES IN GENERAL PARALYSIS.

BY DR. CARL J. HEDIN, WEST POWNAL, ME.

The increasing number of cases of general paralysis admitted to the insane hospitals should make us all interested in the symptomatology of this disease. And it should be of special interest to the general practitioner who, on account of the gradual and insidious onset, often has these subjects under his observation long before they demand hospital treatment. During this early period the disease is often unrecognized, and it is then that many unfortunate occurrences happen which might have been prevented if an earlier and correct diagnosis had been made and proper treatment advised.

Symptomatology: General paralysis is characterized by both mental and physical symptoms. The mental disorders are very marked and it is for this reason that the disease has been classed with the psychoses.

In the incipient stage of the disease, changes of character and disposition tend to become evident. The patient begins to say and do things which only his near associates or intimate friends may notice are strange for him. The moral obligations are among the first to become weakened. A serious man becomes frivolous, a considerate and moral man becomes rude and cynical. In a few weeks, the character of the patient may be so changed that a previously honest, upright, moral and sober individual may become addicted to every form of vice. It is at this time that it becomes of the utmost importance

for the family physician to recognize the beginning of mental disorder and advise proper treatment. By so doing, he may spare the patient from moral disgrace and crime, and save many wives and children from being left penniless through the squandering of fortunes.

In the developed stage of general paralysis, the mental symptoms are characterized by a progressive mental deterioration, shown by a marked general memory defect, impaired judgment, and a gradual weakening of all the mental powers. The memory is usually from the first impaired. The patient cannot remember recent events, while old events may be better retained. He is not able to retain new impressions, or concentrate his attention. Business engagements and details are forgotten and he cannot make easy mental calculations. The defective judgment shows a further advance in the mental deterioration. The patient may enter into ill-advised business relations, or commit some foolish crime which brings him into conflict with the law. As the disease progresses, the change of character becomes more marked, and the patient grows more incapable of mental application or work. With this general intellectual deterioration, there is usually marked emotional indifference and apathy. Temporarily there may be increased irritability, exhilaration or despondency with numerous absurd delusions and hallucinations, but the fundamental change in mood is an emotional indifference, which progresses more or less rapidly into an apathetic dementia.

These mental symptoms of general paralysis are usually accompanied, at an early stage, with physical signs. The most important of these is the loss of the light reflex, with retention of the reaction to accommodation, or the Argyll-Robertson pupil. This is both a frequent and an early symptom, and may precede other symptoms for many years. Often, the pupils early become unequal in size and irregular in outline. Another very characteristic physical symptom is the disturbance of speech, shown by defective articulation, tremor and shaking of the lips during speech. The patient's writing shows tremor, with letters and syllables left out, doubled or transposed. Usually there is also disturbance of the knee-jerks and other reflexes. They may be increased, diminished or lost on one or both sides.

This, in a brief and general way, describes the symptomatology of general paralysis. In the fully developed stage of the disease, on account of certain peculiar mental symptoms, we recognize four types: The demented, the expansive, the agitated and the depressed. The essential characteristics of each type will now be briefly stated followed by a report of illustrative cases. It should be first noted, however, that the fundamental deterioration is practically the same in all the different types, or differ only in degree, and therefore it will be only briefly referred to in the discussion of the types.

The Demented Type. In these cases the symptoms of mental reduction are very prominent. The memory fails utterly. The patient may not remember where he lives. He becomes disoriented for time, place and person. The simplest mental operations, such as adding and subtracting figures, become impossible. The emotional deterioration is marked. These patients are usually in a happy, simple and child-like mood, but pay no attention to their families or friends. There may be absurd delusions of wealth present, which are expressed in an incoherent and indifferent manner. These patients do not realize the importance of their own statements. This emotional indifference and lack of interest in the delusions, is an important differential point between the demented and expansive types. The following case will illustrate the demented type:

G. D. B. 36 years old, single, machinist. Admitted to M. I. H., June 13, 1911. About a year and a half before admission, patient began to become absent minded, forgetful and more irritable than formerly. He became restless and wandered about at night. One day he stretched a net across the street and said he expected to catch a lot of shad. Two weeks before admission, he stole some lobster pots. He was arrested and agreed to return the pots. Two days later he stole the same lobster pots. He was again arrested and declared that the lobster pots belonged to him. He was then committed to the Maine Insane Hospital.

The physical examination revealed sluggish pupillary reaction to light, greatly exaggerated knee-jerks, slight Romberg's sign, fine tremor of tongue and coarse tremor of fingers. The cerebro-spinal fluid was positive to the chemical and cytological tests. He had some difficulty in pronouncing test words, and showed a tendency to omit syllables when reading.

When admitted, patient was quiet and well-behaved, but talked freely. He said he was perfectly well and never felt better in his life. He said this in a simple and indifferent manner without showing any elation. He was poorly oriented. Could not tell the year or date. His recent memory was poor. He forgot where he placed his hat and coat. When playing checkers, he would forget how to move, and moved his men backwards. Four weeks later, he wrote four or five letters a week to a girl friend, and in every letter asked for a dollar in money, a fish line, and if she was willing to marry him. He had a few expansive ideas which he expressed in a simple and disinterested manner. He said he had been around the world several times. Said that he made \$15,000 at mining in California and that he had nuggets worth about \$800 apiece. He said he was at the Battle of Manila

Bay and several other battles of which he could not remember the names. He was in a friendly, simple and indifferent mood. He said he was not insane and felt fine. Since then, the patient has gradually deteriorated more and more, until at present he goes around with his clothes unbuttoned, spills his food on his clothing, and he cannot remember a few minutes later where he placed articles of clothing.

The demented type represents by far the largest number of paralytics. Among 54 cases admitted to Maine Insane Hospital during the past two years, thirty cases, or about 55.5% were of this type. Remissions are rare. About 50% die within two years, and rarely the disease lasts five years.

The Expansive Type: This is sometimes called the excited type. It is characterized by marked emotional elation, motor activity, flight of ideas, and usually delusions of grandeur. These patients are happy and have a feeling of well-being which is out of all proportion to the physical condition. They become over-active and talkative, and sometimes show great pressure in speech and activity. They write many letters, draw up absurd and foolish schemes and show psychomotor activities in many ways. Their expansive ideas are of an absurd character. The patients often believe themselves to possess great strength, power or enormous wealth. These delusions differ, however, from the expansive ideas in the demented type. In the latter, they are the simple and child-like creations of a profoundly deteriorated mind, expressed in a hap-hazard manner. In the expansive type, the delusions of grandeur are active desires and wishes which is the result of the elated mood with defective judgment. Although expansive delusions are very common in this type, they are not essential characteristics. The exalted mood and the marked psychomotor activity present are by far more important symptoms in the grouping of the cases. The following case represents this type:

G. H. P. Age 39, single, laborer, admitted January 7, 1911. Six weeks before admission, patient became excited over the LeBlanc trial. Every morning he went after the newspapers, and ran back to tell the news. He was restless and began to borrow money to travel with. He wrote letters to various people, and began to stay out late nights.

The physical examination showed small and irregular pupils which reacted sluggishly to light. The left knee-jerk was exaggerated and the right diminished. The tendo-achilles reflexes were diminished. The plantar, abdominal and cremasteric reflexes were all exaggerated. The cerebro-spinal fluid was positive for the chemical and cytological tests. His writing showed tremor, with frequent omissions and transpositions of letters.

On admission, patient was talkative, showed flight of ideas and was over-active and restless. He wrote many letters hurriedly, and said he had to write many more. He wanted to borrow money. Said he had to leave on the train "within an hour," "after dinner," or "before dark." He had poor memory for recent events, and made mistakes at simple figures. When reading, patient skipped over words, syllables and lines without noticing it. He was in an extremely happy and elated mood. He sang, whistled and danced. He expressed many expansive delusions. He said he helped to fix the loop around Dr. Crippen's neck and saw him hung. Said he was a drummer and was going to sell flour, all kinds of grain, cigars, cigarettes and chocolates. He said he was going to study law. Thought that he would make the bravest lawyer there was. He said, "I would like to get right into a criminal case today." Said he was going to travel around the world, that he could go from Maine to California for two dollars, and jump across from California to Florida. A month after admission, he said that he weighed 1,380 pounds, and said he could lick a wild-cat, a boa-constrictor and a grizzly bear all at once. Since then, patient has continued happy and elated, but as the deterioration has progressed, his expansive ideas have become less and less prominent.

Among the 54 cases reviewed, 14 cases, or about 26% were of this type. The duration of the disease, is more prolonged in these cases, and remissions are more frequent.

The Agitated Type: This is sometimes called "galloping paresis." It is the expansive type associated with extreme psychomotor excitement, which usually leads to a rapidly fatal course. Restlessness and insomnia become marked. These patients talk, sing, laugh or shout continually. They are in constant motion, going from one thing to another. Their delusions change rapidly, and there is frequently flight of ideas with incoherence of speech. The following is an example of this type:

A woman 29 years old admitted March 3rd, 1910. She came with a history of having had one previous short period of excitement, followed by a remission of several months. During the remission she was unstable and went from one kind of work to another. Four weeks before admission, she suddenly became very excited and noisy. Talked, laughed and was restless at night.

The chief physical signs in this case were dilated pupils with a sluggish light reaction. Highly exaggerated knee-jerks. Tendo-achilles and plantar reflexes increased. Ankle clonus on both sides and petella clonus on the right side. Romberg's sign and unsteady gait.

Muscular power weakened. Tremor of tongue, lips and hands, and a marked speech defect.

When admitted to the hospital, patient was greatly excited. She cried, laughed and shouted. She was disoriented, had a marked recent memory defect, and could not do simple adding and subtracting. She talked incoherently and expressed a few expansive ideas. She said, "I know everything." "I am well educated." "I am happy, I can read and write everything." "This is my house." "I am the head of the house," and so forth. She said that she was extremely happy although she frequently cried for a few moments at a time. Patient continued to be noisy, restless and resistive, until she died six weeks after admission.

Only four cases, or about 7.5% were of this type. In this type the disease usually runs a rapid course, and remissions occur only in a small number of cases.

The Depressed Type: This type is characterized by emotional depression and delusions of a depressive nature. As in the other types, so here, the mood is the essential feature. These patients may be cheerful at times, but generally they are depressed. The depression may be accompanied with retardation, or anxiety and apprehension. Unless the mental deterioration and the physical signs are borne in mind, this type may easily be mistaken for involutional melancholia, or the depressed form of manic depressive insanity. Delusions are frequent, and may take the form of hypochondriacal, self-accusatory, or persecutory ideas. Like in the expansive type, these delusions are characterized by marked absurdity, which is the result of the mental deterioration. The following case will illustrate this type:

J. H. Age 50, carpenter, admitted December 6, 1910. Three months before admission, he became depressed. He threatened to injure himself, but did not attempt it. Said he heard voices tell him to do things.

The important physical signs were as follows: The pupils were small, irregular, and reacted sluggishly to light. The knee-jerks and tendo-achilles reflexes were exaggerated. Tremor of facial muscles and extended fingers. Marked speech defect and tremor in writing.

On admission he was depressed, restless and apprehensive. He worried and feared he would be left out in the woods and stoned to death. Feared that he would see the "devil." He heard voices tell him that he was going to lose his senses. Heard that he was going to be butchered; that he was going to "hell," and that he was lost. He was poorly oriented, had a fair memory, but did simple calculations with difficulty and incorrectly. During the following six months, patient continued to remain restless and depressed. He would walk

the floor, back and forth. Feared something awful was going to happen to him. Thought he would be put into a fire, etc. After thirteen months in the hospital, he was still depressed and restless, but his delusions and hallucinations became less prominent, and he was allowed to leave the hospital on a six months' trial visit at home.

Among the cases considered, six, or about 11%, were of the depressed type. This type seems more frequent in cases where general paralysis developed later in life. Very few remissions occur, and the majority of the cases die within two years.

There still remains two other types to be briefly mentioned. The juvenile and the tabetic types. The juvenile, or the infantile type, is a hereditary form of general paralysis, which occurs during the childhood. During the past twenty years, several of these cases have been reported by both American and foreign observers. Clinically, they are characterized by simple deterioration, choreic disturbances and paralytic attacks. It has never been my privilege to observe or treat a case of this type and therefore I cannot report any.

In the so-called tabetic type of general paralysis, signs of tabes may appear several years before the symptoms of general paralysis. Among the 54 cases grouped, three, or about 5.5% were of this type. The mental symptoms in these cases, do not present any distinguishing features from the other types. In a much larger percentage of cases, tabetic symptoms develop during the later stages of the disease.

***SYMPOSIUM: PARESIS.**

THE ETIOLOGY AND THE EARLY DIAGNOSIS OF PARESIS.

DR. FREDERICK L. HILLS OF BANGOR.

The increasing frequency of paresis and the importance of its early recognition with the hope of arresting its progress, lends an interest at this time to an inquiry into the etiology and a survey of its earliest manifestation. Within the last few years, there has been a marked increase in the frequency with which the diagnosis of paresis is made. Whereas it formerly represented not more than 7 to 10% of hospital admissions, these percentages have been nearly doubled

*Papers read before the Maine Medical Association, June, 1912. Dr. Miller was unable to send in his paper on "Pathology."

in recent years in many instances. It was but a short time ago that paresis was one of the elite among diseases; it was believed to limit its consideration to the educated and well-to-do, and it was more or less of a distinction for a poor man to be the recipient of its attention. But hand in hand with the high cost of living and other luxuries, it has found its way into the homes of the humblest, seemingly oblivious of class distinctions, and is shortening the lives of an increasing number of the common people, as well as of "malefactors of great wealth."

It is a disease ordinarily of middle adult life, becoming manifest usually between the ages of thirty and fifty years, though cases are not infrequent in the decades immediately preceding and following this period. Of one hundred and five cases admitted to the Eastern Maine Insane Hospital during the last four years, the average age of the men was forty and eight-tenths years and of the women, thirty-nine years. Out of seventy-three men, six were between twenty-four and thirty years of age, and eleven were over fifty years old. Of thirty women, two were less than thirty, six were over fifty, the oldest being fifty-four. These are not the ages of admission, but the ages of onset as nearly as could be determined from the histories.

Men are more frequently affected than women, men being more often subject to those things which cause or predispose to the development of the disease. The ratio of its occurrence in men and women is given usually as one to four or five. The Eastern Maine Insane Hospital series showed a ratio of one to two and five-tenths.

Both observation and the study of recent literature leads me to the belief that paresis is occurring with increasing frequency among women.

In studying the etiology of paresis, we find a wide divergence of opinion as to the relative importance of the role played by the various supposedly causative agents. When a new case of paresis presents itself for examination, our most insistent etiological inquiries are relative to the previous existence of syphilis, for we have come to look upon syphilis as prerequisite for its development. A definite history of syphilitic infection is obtainable in a large percentage of cases. There is no other form of insanity so frequently showing history of a former syphilitic infection. In our series, sixty-three per cent gave a positive syphilitic history. Starr states that paresis is a post-syphilitic disease in sixty per cent of the cases, and quotes Mott as giving figures from fifty-four authors ranging from eleven to ninety-six per cent. Doubtless the per cent of cases failing to give evidence of a previous syphilitic infection will be much reduced by the more general adoption of modern laboratory methods, the findings of which are considered elsewhere

in this symposium. Granting however, that the preponderance of evidence favors the syphilitic origin of the disease, there is yet a small number of cases in which no method yet devised reveals the syphilitic taint. When we consider also that only a small percentage of syphilis (probably not more than one to three per cent) ever develop paresis, it seems probable that syphilis is not the only etiological factor, but that other causes may be exciting factors in a person predisposed by a previous syphilitic infection.

Kräpelin advances the theory that paresis is a disease of auto-intoxication; that syphilis produces a disorder of metabolism which results in the formation of a toxic substance, which in its turn causes the lesion of paresis. "Recent studies of the disease," says Rosanoff, "show that a syphilitic antibody produced in excessive amounts may be the toxic factor, which according to the Kräpelin hypothesis, is the cause of paresis. This assumption would account for the positive Wasserman reaction and for the changes in the various organs of the body as resulting from the special affinity which this antibody is known to have for certain tissue lipoids."

Paresis usually becomes manifest from five to twenty years after the initial syphilitic infection, and among the factors which seem to be active in favoring its development, alcohol is conspicuous. The frequency of the combination of syphilis and alcohol is noted by many authors. Kräpelin found excessive alcoholism in sixty per cent of his cases, while Paton ascribes etiological significance to it in from ten to fifteen per cent.

In the cases seen at Bangor, fifty-four and six-tenths per cent of the men gave a history of alcoholic indulgence, and in thirty-four per cent the alcoholism was combined with syphilis.

Heredity was at one time thought to be an important factor in the etiology, but while twenty per cent of our cases gave a history of insanity in the family, we do not attach as much significance to this factor as in most other forms of insanity.

The importance of fatigue and of mental and physical strain in the genesis of the disease has been frequently pointed out, and bearing upon this is an interesting report of two hundred and twenty-four cases by Leige in a paper on the Edinger Exhaustion Theory of Paresis; forty-four per cent of the patients have been engaged in work requiring prolonged physical strain and twenty-one per cent in work attended by mental strain. Over half of those cases, which were of the tabetic type, had been subjected to prolonged physical strain before the onset of the disease. In the study of our cases at Bangor, I have been unable to attach any special etiological significance to occupation or fatigue.

Head traumata, sunstroke, profound emotional disturbance and sexual excesses have all likewise, from time to time, been ascribed with importance in the etiology of paresis, and while they, as well as alcoholism and prolonged mental and physical strain, doubtless played their part as exciting factors, yet in the light of our recent knowledge it does not seem probable that any one or any combination of these causes can result in the development of paresis, unless the patient has a hereditary or acquired syphilitic infection which has produced its characteristic antibody or other toxic agent with the resultant poisoning effect upon the nervous tissues.

EARLY DIAGNOSIS.

Much importance attaches to the early diagnosis of paresis, not only for the welfare of the patient, but for the safety of the public. Not infrequently it happens that a man occupying a position of responsibility and a position involving risk to the lives and property of others, becomes suddenly manic, or by some other overt act reveals the existence of an unsuspected paresis, and in so doing jeopardizes the lives of those in his care. A steamboat engineer with a long record for faithful service, allowed the water to get out of his boiler, and a serious accident was averted only by the presence of mind of a fellow member of the crew. A few days later this man was admitted to the hospital on account of a sudden manic outbreak, showing the typical physical signs and mental state of the paretic. Another patient, a conductor of a freight train, having worked with his crew all night and being tired and hungry, stopped his train and left it standing on the main track one-half hour, while he took the crew to a nearby restaurant. This man was reprimanded, but continued in the service of the road. Later he developed paresis, and it is fair to assume that a careful neurological examination at the time of the occurrence might have shown early signs of the disease.

The onset of paresis is as a rule insidious. Slight anomalies of conduct attract little attention, and it is not until the disease has become well pronounced that the friends of the patient, looking back over the previous several months, recall small memory defects, slips in speech, alteration in character or mode of life, which at the moment seemed trifling, but which looked upon in retrospect are recognized as shadows of the coming event. "There is no disease," says Regis, "so insidious in its onset as paresis." It is therefore impossible to fix definitely the commencement of the process, and it is often well developed before the diagnosis is made. What first really attracts the attention of the patient's friends, or is noted by himself, is as a rule, the development

of neurasthenic symptoms of a hypochondriacal character, and in which a memory defect, more or less marked, is a rather constant and prominent feature. The patient feels somewhat incapacitated, his memory is less acute, his capacity for mental work diminished, and he complains of nervousness, maybe insomnia and sometimes also of obscure neuralgic pains. There is frequently a frontal headache or pain in the vertex, covering a period of several weeks. All of these symptoms are suggestive of the neurasthenic state, but one should be cautious in making the diagnosis of neurasthenia in persons of middle life without first determining the absence of physical signs of early paresis.

Physical symptoms may or may not be manifest at the onset. Slight, sometimes transient, speech defect, changes in the pupils and altered knee jerks are those most commonly noted.

To the question as to whether the mental or the physical symptoms are the first to appear, the answer will mostly depend upon whether the question is asked of a neurologist or a psychiatrist. For the former, the physical symptoms overshadow the mental — which he deems trifling and unsubstantial — as witness the very interesting study of one hundred early cases by Philip Combs Knapp of Boston: "The patient," he says, "may have less power for continued mental effort, lessened initiative, lack of creative faculty, diminished power of attention, some slowness of comprehension or of apprehension and the like, and yet appear in fair mental condition." In twelve of his cases the mental symptoms were slight irritability, nervousness, failure of memory, emotional irritability and a little indifference, but in all of them some physical signs were manifest. "The physical symptoms," he says, "in the early stages of the disease, and even well along in the disease, are more constant and more significant than the mental, and by themselves alone may form a diagnosis even when the mental symptoms seem practically unimportant." In the discussion of this paper, Dr. M. Allen Starr reported twenty cases diagnosed by him as neurasthenia which proved subsequently to be cases of paresis. The most marked mental symptoms of these case were irritability of temper, a slight lack of memory, of mental application and of mental control, but in none of them did a careful examination show anything abnormal in the pupils or the reflexes at the first examination.

A study of the early symptoms in our cases at Bangor gives some interesting information. The histories were sufficiently complete in ninety out of one hundred four cases to warrant the record of the first symptoms or changes in the appearance or demeanor of the patients as noticed by relatives. The first symptoms are given in the following table; they are classified as physical in thirty-two cases

and as mental in fifty-eight cases (sixty-four per cent). There are one hundred fifty-three symptoms reported in the ninety cases in varying combinations, and in ten cases both mental and physical symptoms had been noticed by the relatives. Of the mental symptoms which were first noted in the majority of cases, depression was manifest in twenty-three per cent., euphoria in fifteen per cent, irritability of temper in seventeen per cent, loss of memory in eleven per cent, and neglect of work in about nine per cent. On the physical side, apoplectiform attacks were the first symptom in sixteen per cent, speech defects in twelve per cent, convulsive seizures in five and one-half per cent, and headache in five and one-half per cent.

MENTAL SYMPTOMS.		PHYSICAL SYMPTOMS.	
Mental depression.	21	Apoplectiform attacks,	15
Euphoria,	14	Convulsive attacks,	5
Irritability,	16	Speech defect,	10
Loss of memory,	10	Aphasia,	1
Extravagance,	3	Numbness,	4
Hypochondriasis,	3	Gait affected,	4
Hysteria,	2	Headache,	5
Suicidal impulses,	2	Pain in legs,	1
Nervousness,	3	Indigestion,	1
Violence or excitement,	5		
Erotic conduct,	2	(32 cases)	46
Neglect of work,	8		
Hallucinations,	2		
Jealousy,	1		
Neurasthenia,	3		
(58 cases)			
	97		

The characteristic early physical signs of paresis are speech defect, changes in the pupils, alterations in the knee jerks and hand-writing defects. In but few of our cases has it been possible to obtain information bearing upon these points at the onset of the disease, our knowledge of these symptoms coming almost wholly from the examination at time of admission. Therefore, for the purpose of this paper, the data from these records is not applicable.

We know, however, that very early in the disease varying combinations of these symptoms can be elicited by careful examination. The pupillary changes most common are irregularity in the pupillary outlines, sluggish reaction to light, inequality of the pupils and the Argyll-Robertson pupil. The knee jerks early become exaggerated, sometimes diminished, or more rarely, lost. The speech defects are seen early in many cases: at first there is a little slurring, especially of the labial and lingual sounds, without any break in the flow of words;

later there is a hesitancy, or the development of a scanning speech, but at first the defect is not constant and is most noticeable under stress of excitement or haste. Sometimes the patient is conscious of this defect and is irritated or depressed thereby. Often there is a fine fibrillary tremor of the lips and tongue, the tremors being more pronounced during articulation. The handwriting also shows a fine tremor, which is most noticeable in the up strokes and the omission or substitution of letters. These are the four cardinal early physical signs of paresis. Hand in hand with them go the mental symptoms previously described, the early picture being ordinarily one of neurasthenic or hypochondriacal depression in combination with one or more of the above physical findings.

Occasionally, however, the disease has an acute onset, with a sudden manic attack or with a convulsion or an apoplectiform seizure, the effects of which are transitory, no pronounced paralytic residuals being left. Twenty-two per cent of our cases gave a history of a sudden onset, in sixteen per cent the first symptoms noted being a sudden transitory apoplectiform attack.

The early diagnosis of paresis is much easier in cases of this character than in those cases with early neurasthenic symptoms; but the true neurasthenic is more introspective, notices his symptoms more, and wants to discuss them in detail; whereas, the early paralytic is apt to minimize his symptoms, to talk less about them than about himself and to show a memory defect more real, and pupillary and speech defects not seen in neurasthenia. If to these symptoms, we are able to add the evidence of a lumbar puncture which will often show a leucocytosis in an early stage, we can feel reasonably sure of our diagnosis.

It is sometimes difficult to differentiate early paresis from cerebral syphilis, but in the latter we are apt to get paralytic residuals, which are absent in paresis, aphasia rather than paretic speech defects; also hallucinations are more prominent and the memory defect is less pronounced.

Paresis coming on late in life must be distinguished from arteriosclerotic insanity, and while in the latter the predominance of the physical symptoms over the mental is significant, our chief reliance for a differential diagnosis must be placed in the findings of a lumbar puncture.

LABORATORY AIDS IN DIAGNOSIS OF GENERAL PARALYSIS.

BY HERBERT E. THOMPSON OF BANGOR.

This paper is to bring to your attention the laboratory methods used in the diagnosis of general paralysis. In the case of general paralysis we have no reaction which is specific like the Widal reaction for typhoid and a few other reactions of that type. There are, however, several laboratory tests which can be applied to the blood serum and cerebro-spinal fluid of patients, the results of which make important links in the chain of evidence for or against the disease.

First in order will be to determine the presence or absence of etiological factors. Syphilis having been accepted as an important etiological factor, the Wasserman reaction, which is the syphilitic test absorbing the attention of the medical profession at the present time, becomes useful. In looking over the literature on this subject, one is struck with the wide variation in the results reported by different investigators.

Plaunt of Munich, in a series of cases, working with the original Wasserman method was able to obtain positive reactions on the blood serum of nearly all paralytics. Nearly every prominent worker with the Wasserman has modified the technique in one way or another so that a comparison of results reported is unsatisfactory. There is a wide variation in these reports. There are several factors which may be responsible for this, but probably the greatest one is the lack of a uniform technique.

At the Eastern Maine Insane Hospital, twenty-four cases of undoubted general paralysis gave only twelve positive reactions or 50%. A modification of the original Wasserman was used in these tests.

Dr. Charles L. Dana in discussing this subject said that he thought the entire question would have to be revised a year or two hence as the methods would probably undergo a change. "The variability of the results at present reported were probably due, not to the character of the disorder, but to the character of the laboratory methods." Other factors such as the stage of the disease and previous treatment, doubtless have an effect upon the reaction. It may be well to emphasize here that the Wasserman is a test for syphilis, and not a test for general paralysis.

We will next consider the examination of the cerebro-spinal fluid. The fluid, for this examination, is obtained by lumbar puncture performed in the usual manner. (Whenever the patient is able to sit up we have found the following method very satisfactory. The patient is seated on a small, firm stand bending forward as far as possible.

An assistant stands facing the patient with the left arm back of the patient's neck and the right arm on the crest of the ileum for a landmark. This position separates the spinous processes. The space between two processes on a level with the crest of the ileum is chosen, and the needle directed straight inward). The one important point is this: *The fluid must be free from blood.* Since the fluid as well as the blood serum may contain the syphilitic antibody, the Wasserman reaction finds application here.

It has been found that, in cases of general paralysis, there is an excess of globulin in the cerebro-spinal fluid. There are several methods for determining this increase but probably the most used are the Ross-Jones test and the Noguchi method. We have used the Noguchi method entirely, and it is performed as follows: Two parts of cerebro-spinal fluid and five parts of a 10% butyric acid in 0.9% salt solution are placed in a small test tube and heated to boiling. One part of normal sodium hydrate is then added and the mixture boiled again. The test is pronounced positive when a granular or flocculent precipitate appears within two hours. This precipitate will settle to the bottom of the tube on standing.

Noguchi, in his book, "Serum Diagnosis of Syphilis," says: "This reaction I have found to appear regularly in the cerebro-spinal fluid of patients with syphilitic and parasyphilitic affections, and also in all cases of inflammation of the meninges caused by such micro-organisms as diplococcus intracellularis, pneumococcus, influenza bacillus, tubercle bacillus, etc. These acute inflammatory infections are of course, readily differentiated from the syphilitic affections. Normal cerebro-spinal fluid gives, with the butyric acid test, a slight opalescence and sometimes a marked turbidity, but the granular precipitate does not occur at all or occurs only after several hours, or even after twenty-four hours."

The results obtained by many who have used this reaction do not bear out entirely the claims made by Noguchi.

Dr. F. W. Mott, pathologist to the London County Asylums, in his Oliver-Sharpey lectures on cerebro-spinal says that he has obtained positive reactions in many non-specific cases; in fact, in all cases of dementia whether non-specific or specific.

W. H. How, at the government for the insane, Washington, D. C., reports positive results in 48% of his non-paretic cases.

James V. May, formerly pathologist to the Binghamton State Hospital, New York, says: "It is beyond dispute that there is an increase of the globulin content in the spinal fluid in cases of general

paralysis, although it occurs in other psychoses as well and is not absolutely diagnostic of the disease."

We have examined several cases which were undoubtedly not general paralysis, which have given a positive reaction. Every case of paresis, however, has without exception, reacted positively: i. e., 100%. Therefore, it seems safe to conclude that a negative result is important, as it is strong evidence against the disease. The most valuable point in the examination of the cerebro-spinal fluid of paretics is the cytology. Cases of general paralysis show a large increase in the number of cells present in the fluid, with an increase in the percentage of lymphocytes. There are many methods for determining this increase of cells.

One of the most used methods is that of Widal and Ravaut, where the fluid is simply centrifuged and the sediment examined. Another method is to treat the fluid with formalin before centrifugalizing. Many use the Fuchs Rosenthal counting chamber, where the fluid is mixed with some stain to color the cells and the number of cells per c. m. m. ascertained. But the method which is undoubtedly the most satisfactory, although rather difficult and time consuming, is the one advised by Alzheimer, which is as follows: 5 cc. of fluid is mixed with 10 cc. of 95% alcohol. This forms a flocculent precipitate of the proteid throughout the fluid. This is centrifugalized for an hour at a high rate of speed. This throws the precipitate down, taking with it all the cells and forms a coagulum, in the bottom of the tube, shaped like a half pea. This coagulum contains all the cells in the 5 cc. of fluid. This coagulum is treated with alcohol, alcohol and ether, ether, thin celloidin and then mounted on a block in thick celloidin. It is imbedded in celloidin like any tissue and sections cut on a microtome. These sections are stained with carbol-methyl-green-pyronin stain, and the average number of cells in 100 oil immersion fields determined, counting fields in several different sections.

In normal fluids the cell count is very low, sometimes being as low as eight or ten cells in 100 fields. In cases of general paralysis, the cell count is very much higher, ranging from nearly a hundred to two or three thousand.

A series of cases (13) at the Eastern Maine Insane Asylum showed an average count of 289 for 100 fields (76-1275) with an average of 81.5% of lymphocytes (61-97). Dr. Henry A. Cotton, formerly of Danvers State Hospital, after examining a large series of cases of the Alzheimer method, concludes that a count of 100 cells or over to 100 fields is the strongest evidence in favor of a diagnosis of general paralysis.

In conclusion, I wish to say:

First: The Wasserman reaction needs to be more thoroughly understood and a universal technique adopted before its relation to general paralysis is established.

Second: The butyric acid test for increased globulin is not diagnostic of general paralysis, or even of inflammatory conditions of the meninges, as it has been found by several observers in other conditions. A negative reaction, however, is weighty evidence against the disease.

Third: The most reliable evidence is furnished by the cytological examination, where in cases of general paralysis, we find a large increase in the number of cells present with an increase in the percentage of lymphocytes.

Dr. Gordon: The principal thing of interest to my mind in this discussion is to show what is absolutely being done in insane hospitals. Those of you who have kept in touch more or less with the arrangements for caring for the insane, for a good many years, know very well we had no such papers as these that we have had the pleasure of listening to today. It simply shows a new departure entirely from the old methods. Today, hospital treatment for the insane is entirely different perhaps from what it was fifteen or twenty years ago. It is well worth while for any member of this society if they have a day that they can spare to spend it either at Bangor or Augusta, and observe, carefully, in connection with the doctors in these institutions, what they are doing. They are treating patients absolutely the same as they are treated for other diseases; they are requiring that the patients shall be sent to them as early in the disease as possible. That is one of the essential things that these physicians insist upon, and then after the patient is sent to the hospital, they are studied precisely the same as we study our cases in private practise. Formerly, as you know, insane hospitals were simply places where it was safe to keep insane patients. If they got well—if their powers of life were sufficient to carry them through and restore them to health, well and good, but there was not very much done for them except to do all the kindly acts that could be done to such patients. Today, the thing has changed. We are studying the cases of the insane exactly the same as we study any other case in our normal private practise.

Of course in five minutes in which to discuss a matter of this kind and importance, I can hardly go into the details such as are being pursued in the various hospitals throughout the State. It is a matter of constant study, investigation and progress. Each of these hospitals have regular clinics two or three times a week and all causes are completely covered and notes of the various members of the staff compared and given throughout a hearty investigation of all cases. It is no longer a place to confine the person who is mentally incapacitated, but every case is as systematically studied and prescribed for as we would study and prescribe for a patient in our daily round of practise. The cases are not taken on trust any longer, but each case is thoroughly investigated by persons who understand their business and who know what can best be done to care for these patients. That is what is aimed at now in all our insane hospitals—to care for our patients—no matter what the cause of the trouble, whether physical or mental. The method of caring

for this class of patients has been entirely changed and the old method with which many of us have been familiar and have dreaded, has entirely passed out. For instance in none of our insane institutions today, is there any effort made to restrain the patients in any way—no physical restraint is put upon any patient. There are no longer any handcuffs or straight-jackets; nothing of that kind that may be called physical restraint. You may ask what becomes of the very wild, maniacal patients. They are simply undressed and put into night-dresses and put in warm baths and kept there for hours and hours if necessary. They soon yield to that treatment and really it is remarkable to see what this method of treatment will do for some of the wildest and most maniacal patients, and this treatment is now in very general use in the insane hospitals throughout the country and is helping wonderfully.

Addison S. Thayer of Portland: Mr. President—I think your committee of arrangements are very much to be congratulated upon securing specialists to entertain and instruct us so well upon this special matter. I have been a visitor as you know to our insane hospitals of this State, and so have had a share in the various reports which the Association has had to listen to, however dull they have been, before now.

I think the great change which Dr. Gordon has spoken of in the last fifteen years is due in a great measure to the waking up of the asylums by Dr. Weir Mitchell. He told them they were asleep, and they went about proving themselves to be very much awake.

I want to make a statement which may seem to be something of an exaggeration, but is the truth as I have found it after some years of experience and a good deal of medical teaching. I want to say that in all the field of medicine and surgery there is no field which is more susceptible to the fourth year students than this field of mental disease. During the last year, the senior students have made four trips to Augusta and they have spent four whole days in the clinical department studying the mental diseases and they have come back wonderfully interested in the work that is being done there. On two successive years, our senior class made visits to Bangor and were similarly interested in the work there.

There is a fascinating opportunity to interest both doctors and students of mental diseases, and it seems to me there is no phase of healing of greater importance or greater interest than this subject of paresis that we are considering; it is concrete and it is difficult to get at without careful investigation. A man announced calmly one morning at breakfast that during a recent trip he had married a servant girl and when inquired into, this statement led to the discovery that the man was affected with paresis. Another man drew a draft for forty thousand dollars which caused the man to be distrusted and later on other symptoms of paresis were discovered. In this very spot a man was once tried for murder and sentenced to Thomaston but he died in Augusta of paresis, the disease which was the actual cause of his so-called crime.

We, of course, are interested in the pathology as presented by Dr. Miller, and Dr. Thompson, but I think the symptomatology by Dr. Hills and Dr. Hedin is more practical for us, and we may, perhaps, as the result of the opportunities we have had here today, be able possibly to prevent extravagance or even prevent a tragedy and some of us may have a chance to prevent injustice being done to some sufferer of this disease.

President: I have the pleasure of introducing to the members of the Association one of our older Presidents, Dr. Swift. Doctor, we will be very

glad to extend to you the courtesy of the floor if you would like to say something to us for a few moments.

Dr. Swift: I am sure I am very grateful for this invitation to speak a few words to you. I had not expected to say anything and am not prepared to do so. I might say I have been very much interested in all your papers and have been greatly impressed by them. The subject seems to have been taken up from its various and many sides. Your views in regard to the pathology I think only emphasizes what Dr. Miller has so ably said regarding general paralysis. We are in a position to say now from an examination whether the case is general paralysis or to what the symptoms tend. The symptomatology seems to have been so fully covered that there is not much more left to be said, but just now I have in mind a case of five or six years' duration, which is a typical case and yet the pupils are fairly normal to light and I think that is general paralysis but perhaps lacking some of the physical signs. I was greatly interested in what Dr. Hills said of contributory causes in these cases of paresis. It seems to be agreed upon that the great general cause is syphilis, and I believe we cannot lay too much stress on this decision, and yet there are other causes as well to which we should give our attention. Another general cause of paresis I have satisfied myself is found to be, a large percentage, perhaps twenty-five or thirty per cent, hereditary in the ancestry. If we could prevent or lessen the matter of bringing children into the world by these parents who are affected by the several causes of paresis that have been designated here, we would have taken a long forward step toward stamping out the disease in coming generations, and general paralysis would diminish to some extent just the same as some of the other diseases will do when we are able to regulate these matters to a certain extent. Then too, alcohol plays a large part, I believe, in the making of general paralytics. We have to deal with alcohol in all these matters, and in the production of paresis it is a conspicuous factor without doubt, and as Dr. Hills has said, the frequency of the combination of syphilis and alcoholism has been noted by most practitioners, and these are without doubt two of the principal contributory causes of paralysis which are worthy of grave consideration.

NOTICE.

Any member in good standing in the State Association, wishing to serve as a delegate to the meetings of other State Societies, should communicate with the President, Dr. R. H. Marsh, Guilford, at an early date.

SURGICAL SUGGESTIONS.

Crinoline gauze provides a better body for plaster bandages than soft gauze. The plaster should be spread evenly into the meshes. To be most serviceable a plaster bandage should be very loosely rolled. It may be kept air-tight in gutta-percha sealed with chloroform.—*American Journal of Surgery.*

If a sepsis of unknown origin is associated with a positive blood culture, don't fail to examine the ears. Sinus involvement from otitis media may be present with little objective evidence and no other symptoms than fever and chills.—*American Journal of Surgery.*

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

Specialists in Germany.

It is a curious fact that the specialists in all the larger cities in Germany have steadily increased of late years, but more curious still that so large a proportion of them should be gynecologists, who so far outnumber all other classes of specialists that their number can only be equalled by combining the surgeons and orthopædic surgeons. After these two sets of specialists, come the oculists, nose and throat specialists and finally those interested in skin diseases and pediatrics. The number of specialists has also in the last ten years increased, those following gynæcology showing the greatest percentage of all.

The actual workings of the British National Medical Insurance Law, shows that practitioners are obtaining an average of one shilling a visit. Some have reported actual visits at two shillings, others only at eight pence, and in one scantily populated district the calls produced about six pence a visit. Taking our own currency and calling a penny, two cents, we find that visits under the new law have brought in a maximum of fifty cents, and a minimum of twelve cents. We shall have to be on the alert to prevent such small means of subsistence being earned in this county ere long, for similar schemes are on the road. This Association should make an effort at the next legislature to insist that the accounts of the attending physician under any employers' liability law should be a first lien on compensation granted for illness or disease.

Medical Wit.

The present anxiety concerning the condition of the Pope of Rome recalls an anecdote concerning another Pope who was far from beloved by his people.

Pope Adrian, the Sixth, who flourished some four hundred years ago, wearied of his duties which the excessive heat one summer made more painful to endure than ever before, retired to his villa, where he was attacked with a slight fever which seemed free from danger and was regarded by the physicians in attendance as of no concern. Despite their opinions, things went worse with the Pontiff, the doctors were still very thoughtless of his condition and he died suddenly, without even having time to get ready to appear before his Heavenly Master. But so hated was the personality of the man, that the news of his death caused universal joy and happiness in Rome. On the following morning, after arrival of the news of his death, there was to be seen the extraordinary spectacle of the front door of the mansion of his body physician, Dr. Giovanni Antracino, decorated with an enormous wreath of flowers, and attached to it a label that could be read across the street: "The Senate and the People of Rome, to the Liberator of the Fatherland."

Editorial Staff.

The Editorial Staff of the Journal has undergone changes which will prove of great value in that they materially strengthen this body. Dr. James A. Spalding accepted an invitation to become a member of the Editorial Staff. He has always been interested in medical literature, and an extensive reader and writer on medical matters. Dr. W. Bean Moulton, who is completing his five years as Secretary of the State Association and was one of the active workers in its re-organization, will also become a member of the Staff.

This gives a body of five men, all independent thinkers who will pass upon all matters before admission to the Journal. They earnestly seek the co-operation of the members of the State Association in their effort to make the Journal of value to all members.

State Meeting.

Every effort is being made by the Committees in charge to make this year's session of the Maine Medical Association of greater interest to its members, as well as more enjoyable, than any of the preceding meetings.

The Program Committee have endeavored to secure a varied and

valuable program while the essayists, who were invited to write, have been, invariably, men interested in their particular line of work and we can surely promise to all members who attend, a most valuable treat, in the material laid out in store for them.

The Entertainment Committee of Cumberland County has just taken up their work of providing entertainment for the members of the Association and their wives, and there is every assurance to believe that the City of Portland will give all the visiting members and their families a hearty welcome.

Better plan your vacation for the last week in June and if there is any question, communicate with the Secretary at an early date.

Medical Legislation.

The Journal has secured a copy of the new laws enacted at our last Legislative Session and will print them under the heading of "Medico-Legal."

There are four matters of particular interest, two of which were reported in the last issue. The third, which was an act to create a State Board of Charities, was finally passed. This is a most important piece of Legislature and we urge each member to become familiar with this particular act. The fourth measure was the Osteopathic Bill, which was finally killed in the Senate through the active work of two of its members, Drs. H. M. Moulton, Cumberland Center and J. H. Patten, Bar Harbor.

The medical members of the House and Senate worked hard to defeat this measure, but the final result is due wholly to the two members of the Senate, one of whom has written to the Journal urging that the State Association give this matter careful consideration before the next Legislative Session and stand ready to deal with the problem in the most logical manner.

There was a time when the idea was prevalent that a medical man should not become involved in politics. This period has passed and we sincerely hope that a greater number of the medical profession in Maine will take active part in the formation of laws, more particularly those of medical nature and even though we may none of us become Legislators, each man could use his influence towards obtaining better laws for the protection of mankind.

SURGICAL SUGGESTION.

Friar's balsam (tinct. benzoin comp.), to be reapplied from time to time, forms a protective film quite useful for wounds of the mucous membranes (as after operations in the mouth or anus and for other moist surfaces, e. g., cracked nipples.—*American Journal of Surgery*.)

Necrology.

LEANDER DIXON RAND.

FAIRFIELD, MAINE, 1863 - 1911.

Dr. Rand was born in Pittsfield, Maine in 1863, studied in the local schools and graduated at the Maine Central Institute. He then went to Detroit, Michigan, where he taught school for some time, and then taking up medicine was graduated at the Medical Department of the University of Vermont. He practiced a while in Canaan, Maine, and next removed to Fairfield, where he practiced the rest of his life. In 1904, he became a partner in the practice of Dr. Frank J. Robinson. He married Miss Addie Wells, daughter of the late Gideon Wells of Clinton, in October, 1890, and she survives him.

On the afternoon of Friday, April 7, 1911, Dr. Rand returned from a visit to a patient, proceeded at once to his office, but he hardly opened the door when he was stricken with paralysis, after what appeared to be nothing but a mere stumble on the threshold. Acute symptoms soon supervened and on the following morning, he was dead. He had died in harness, as he had often wished might occur to him.

J. A. S.

ALBERT WOODSIDE.

ROCKLAND, MAINE, 1847 - 1912.

Dr. Woodside was the son of Calvin and Emily Whittun Woodside and was born in Wales, Maine, July 12, 1847. He fitted for college at the Edward Little Institute in Auburn and was graduated from Bowdoin in 1869. He taught school first in the West, and later on was Principal of Monmouth Academy, Maine. He then turned his mind to the study of medicine, and watched the practice of the venerable Dr. Alonzo Garcelon and later that of the skillful Dr. Edward Henry Hill of Lewiston and finally obtained the degree of M. D. at the Medical School of Maine in 1874.

Dr. Woodside settled first at Tennant's Harbor, and remained there until 1891, when he removed to Rockland, where he practiced during the remainder of his life. He was a student of medicine always, a man of magnetic influence with his patients, and kindly in all respects to those who entrusted themselves to his care. He wrote many medical papers for local societies, and gave much service to Rockland when on the school board.

He married June 23, 1875, Miss Alice Skolfield Hunt, who with two children, survive him. Compelled in later years to exercise great caution so far as regards his own bodily condition, he administered to others until a few months before he began to fail rapidly from various complications of disease.

J. A. S.

Medico - Legal.

Maine.

[Revised Statutes, 1903, Chapter 18.]

SEC. 1. **State board of health, how constituted.** — The State board of health as heretofore established shall consist of six members, appointed by the governor, with the advice and consent of the council, and a secretary, elected as hereinafter provided. The governor, with the advice and consent of the council, shall annually appoint a member of said board to hold office for six years from the 31st day of January of each year any vacancy occurring during a term among the members so appointed shall be filled in like manner for the remainder of the term. The members so appointed by the governor shall elect a secretary, who shall, by virtue of such election, become a member of the board and its executive officer. The board may elect one of their own number secretary, in which case his term of office as a member by appointment of the governor shall expire, and the governor, with the advice and consent of the council, shall appoint another member to complete the full number of the board.

SEC. 2. *Powers and duties.* — The State board of health shall have the general supervision of the interests of health and life of the citizens of the State. They shall study the vital statistics of the State and endeavor to make intelligent and profitable use of the collected records of deaths and of sickness among the people; they shall make sanitary investigations and inquiries respecting the causes of disease and especially communicable diseases and epidemics, the causes of mortality, and the effects of localities, employments, conditions, ingesta, habits and circumstances on the health of the people; they shall investigate the causes of disease occurring among the stock and domestic animals in the State and the methods of remedying the same; they shall gather such information in respect to all these matters as they may deem proper for diffusion among the people; they shall, when required or when they shall deem it best, advise officers of the Government, or other boards within the State, in regard to the location, drainage, water supply, disposal of excreta, heating, and ventilation of any public institution or building; they shall from time to time examine and report upon works on the subject of hygiene for the use of the schools of the State; they shall have general oversight and direction of the enforcement of the statutes respecting the preservation of health; and they shall, in the month of January, make report to

the governor and council of their doings, investigations and discoveries during the year ending on the 31st day of December, with such suggestions as to legislative action as they may deem necessary.

SEC. 3. *Meetings.* — The board shall meet quarterly at Augusta and at such other places and times as they may deem expedient. Suitable accommodations for the meetings of the board and office room for its secretary shall be provided at the State capitol. A majority shall be a quorum for the transaction of business. They shall choose annually one of their number to be their president, and may adopt rules and by-laws subject to the provisions of this chapter. They may send the secretary, or a committee of the board, to any part of the State when deemed necessary to conduct an investigation within the scope of their prescribed work.

SEC. 4. *Secretary.* — The secretary shall hold his office as long as he shall faithfully discharge the duties thereof; he may be removed for just cause at a regular meeting of the board by vote of a majority of the members. He shall keep his office at the State capitol, and shall perform the duties prescribed by law or required by the board. He shall keep a record of the transactions of the board; shall have the custody of all books, papers, documents, and other property belonging to the board which may be deposited in his office; shall, as far as practicable, communicate with other State boards of health and with the local boards of health within this State; shall keep and file all reports received from local boards of health and all correspondence of the office appertaining to the business of the board. He shall, as far as possible, aid in obtaining contributions to the library and museum of the board. He shall prepare blank forms of returns, and such instructions as may be necessary, and forward them to the local boards of health throughout the State. He shall collect information of the board. He shall keep a record of all specimens sent to him for concerning vital statistics, knowledge respecting diseases, and all useful information on the subject of hygiene, and, through an annual report and otherwise, as the board may direct, shall disseminate such information among the people.

SEC. 5. *Salary.* — The secretary shall receive an annual salary which shall be fixed by the State board of health. The board shall quarterly certify the amount due him, and on presentation of said certificate the governor shall draw his warrant on the treasurer of State for the amount. The members of the board shall receive no compensation for their services, but their travelling and other necessary expenses while employed on the business of the board shall be allowed and paid.

SEC. 6. *Appropriation.* — The sum of \$5,500 shall be annually appropriated to pay the salary of the secretary, meet the contingent expenses of the office of the secretary and the expenses of the board, which shall not exceed the sum appropriated. Said expenses shall be certified and paid in the same manner as the salary of the secretary.

SEC. 7. *Public health information.* — In order to afford to this board better advantages for obtaining knowledge important to be incorporated with that collected through special investigations and from other sources, all officers of the State, the physicians of all incorporated companies, and the president or agent of any company chartered, organized, or transacting business under the laws of this State, as far as is practicable, shall furnish to the State board of health any information bearing upon public health which may be requested by said board for the purpose of enabling it better to perform its duties of collecting and distributing useful knowledge on this subject.

SEC. 8. *Inspection, etc.* — The more effectively to protect the public health the State board of health may establish such systems of inspection as in its judgment may be necessary to ascertain the actual or threatened presence of the infection of Asiatic cholera, smallpox, diphtheria, scarlet fever, plague, or typhus fever; and any duly authorized agent or inspector of said board may enter any building, vessel, railway car, or other public vehicle to inspect the same and to remove therefrom any person affected by said diseases and for this purpose he may require the person in charge of any vessel or public vehicle other than a railway car to stop such vessel or vehicle at any place, and he may require the conductor of any railway train to stop his train at any station or upon any sidetrack and there detain it for a reasonable time: *Provided*, That no conductor shall be required to stop his train when telegraphic communication with the dispatcher's office can not be obtained or at such times or under such circumstances as may endanger the safety of the train and passengers: *And further provided*, That any such agent or inspector may cause any car which he may think may be infected with any of said diseases to be sidetracked at any suitable place and there be cleansed, fumigated, and disinfected. And the said board of health may from time to time, make, alter, modify, or revoke rules and regulations for guarding against the introduction of any infectious or contagious diseases into the State, including rabies, or hydrophobia, of animals and men; for the control and suppression thereof if within the State; for the quarantine and disinfection of persons, localities, and things infected or suspected of being infected by such diseases; for the transportation of dead bodies when death results from any infectious or contagious disease; for the speedy and private interment of the bodies of persons who have died from said diseases;

and, in emergency, for providing those sick with said diseases with necessary medical aid and with temporary hospitals for their accommodation and for the accommodation of their nurses and attendants. And the said board may declare any and all of its rules and regulations made in accordance with the provisions of this section to be in force within the whole State, or within any specified part thereof, and to apply to any person or persons, family, camp, building, vessel, railway car, or public vehicle of any kind.

SEC. 9. *Rules and regulations.*—Any rules and regulations adopted by the State board of health in the premises shall be immediately submitted by it to the governor and council, and unless approved in writing by the governor and council within 30 days after such submission such rules and regulations shall thereafter become ineffective. Should the governor and council disapprove any rules and regulations so submitted to them within 30 days and so notify the secretary of the State board of health in writing, the rules and regulations so disapproved shall, upon such notification, immediately become ineffective and void. Such rules and regulations, if of general application, shall be published in the State paper; but whenever, in the judgment of the board, it shall be necessary to do so, special rules and regulations or orders relating to said disease may be made for any town, village, or city without such publication, and the service of copies of such rules, regulations, or orders upon such town, village or city through the officers thereof shall be a sufficient notice thereto; and the rules, regulations, or orders of the State board of health made in accordance with the provisions of this section shall, for the time being and until the same are revoked, supersede all local rules, regulations, by-laws or ordinances that may be inconsistent or in conflict therewith.

All health officers, local boards of health, municipal officers, sheriffs, constables, police officers, and marshals shall enforce the rules and regulations of the State board of health made as provided in the two preceding sections in every particular affecting their respective localities and duties; and any person who shall neglect or refuse to obey the said rules and regulations, or who shall wilfully obstruct or hinder the execution thereof, shall be punished by a fine of not more than \$500, or by imprisonment in the county jail for a period of not more than six months, or by both fine and imprisonment. And all authorities of every county, city, town and village corporation, all local boards of health, and all officers and persons in charge of the institutions, buildings, and vehicles mentioned in section 8 shall co-operate with the State board of health in carrying out the provisions of this section and the two preceding sections; and in case such co-operation

be refused, withheld, or neglected, the said board may execute its orders and directions by agents of its own appointment; and all expenses incurred by members of the State board of health or by duly appointed agents of said board under the provisions of this section shall be paid by the State, the bills being first approved by the governor and council.

SEC. 21. *State laboratory of hygiene.*—The State board of health may establish and equip with the proper and necessary apparatus, instruments, and supplies, a State laboratory of hygiene, for the chemical and bacteriological examination of water supplies, milk and food products, and the examination of cases and suspected cases of diphtheria, typhoid fever, tuberculosis, glanders, and other infectious and contagious diseases.

SEC. 22. *Director.*—The State board of health shall appoint a director of such laboratory who shall hold that position at the pleasure examination, and examine these specimens without unnecessary delay, and do such other work and make such other investigations relating to the public health as said board may from time to time direct. He shall annually in the month of January make a full report to a board of all matters pertaining to the laboratory, and shall make such other and special reports as the board may require. The kind and amount of the work he shall do and the compensation therefor shall be fixed by said board. The services of the laboratory and all investigations therein made shall be free to the people of the State.

SEC. 23 (as amended by ch. 26, acts of 1907). *Appropriation.*—The sum of \$4,500 a year is hereby appropriated to pay for the services of the director and of such assistants as may be necessary, to procure the necessary supplies, and to meet the other necessary expenses of said laboratory, which sum shall be expended under the supervision of the State board of health.

[Acts of 1911, chapter 289, page 645.]

State Board of Health.

For contingent expenses of the board, including salary and expenses of the secretary, traveling and other necessary expenses of the other members of the board, clerk hire, stationery, postage, express, telephone, telegraph, books and sanitary journals, etc., as provided by chapter 48, section 1, public laws of 1909	\$5,500
For printing and binding reports of department, and for circulars, blanks, etc.	2,000
For the registration of vital statistics, including actual traveling and other necessary expenses of the registrar, clerk hire, etc., as provided by chapter 75, sections 6 and 8, public laws of 1909	3,000

For the salary of the director, necessary assistants, and for necessary supplies and expenses of the State laboratory of hygiene, as provided by chapter 18, section 23, revised statutes, as amended by chapter 26, public laws of 1907..... 4,500

[Revised Statutes, 1903, chapter 18.]

SEC. 24. Appointment and organization of local boards.—There shall be a local board of health in each city and town in the State, to be composed of three members appointed by the municipal officers, anything in the charter of such city to the contrary notwithstanding; the board first appointed in any town shall be appointed to serve, one for three years, one for two years, and one for one year, and thereafterwards the municipal officers in each town shall annually before the 15th day of April, appoint a member of such board to serve three years and to hold office until another is appointed in his stead. Any vacancy arising from any cause shall be filled for the unexpired term at the first meeting thereafter of the municipal officers. If for any reason the appointments are not made at said date the same shall be made as soon as may be thereafter.

SEC. 25. If the municipal officers of any city or town shall fail to appoint a local board of health, or to fill any vacancy in said board, in accordance with the provisions of the preceding section, the secretary of the State board of health may in writing request such municipal officers to make such appointment, and if the municipal officers shall neglect or refuse to do so for a period of 30 days after receiving such written request, the State board of health may appoint such local board of health, or fill any vacancy therein.

SEC. 26. Before the 15th day of May in each year the board of health shall meet for the transaction of business, and shall choose a chairman and secretary from their number.

SEC. 27. The chairman shall preside at all meetings of the board. The secretary shall, in a book kept for that purpose, make and keep a record of all the proceedings at the meetings and of all transactions, doings, orders, and regulations of the board of health. The secretary shall be also the executive officer of the board when a health officer is not appointed.

SEC. 28. The municipal officers may appoint a health officer, who shall be a well-educated physician, who shall be the sanitary adviser and executive officer of the board, and who shall hold office during the pleasure of the board. The municipal officers shall establish his salary or other compensation, and shall regulate and audit all fees and charges of persons employed by each board of health in the execution of the health laws and of their regulations.

SEC. 29. *Powers and duties of local boards.* — The health officer, or where there is no health officer appointed, the secretary of each local board of health, at least once in each year shall report to the State board of health their proceedings, and such other facts required, on blanks, and in accordance with instructions received from said board. He shall also make special reports whenever required to do so by the State board of health. He shall, within one week following their meeting and election of officers, report to the secretary or the State board of health the name and address of each member of the local board, of the chairman and secretary, and of the health officer when one is appointed.

SEC. 30. Each local board of health constituted under section twenty-four shall:

(1) Hold regular quarterly meetings, and special meetings whenever considered necessary by its executive officer; also whenever requested by the State board of health, or the president and secretary thereof.

(2) Prescribe the powers and duties of the local health officer when there is one, and direct him from time to time in the performance of his duties.

(3) (As amended by ch. 78, acts of 1909.) Guard against the introduction of contagious and infectious diseases by the exercise of proper and vigilant medical inspection and control of all persons and things coming within the limits of its jurisdiction from infected places, or which for any cause are liable to communicate contagion; give public notice of infected places by displaying red flags or by posting placards on the entrance of the premises; require the isolation of all persons and things that are infected with, or have been exposed to, contagious or infectious diseases, and provide suitable places for the reception of the same; and furnish medical treatment and care for persons sick with such diseases who can not otherwise be provided for; prohibit and prevent all intercourse and communication with, or use of, infected premises, places and things, and require, and if necessary, provide the means for the thorough cleansing and disinfection of the same before general intercourse therewith, or use thereof, shall be allowed. And it shall report to the State board of health promptly, facts which relate to infectious and epidemic diseases, and every case of smallpox, varioloid, diphtheria, scarlet fever, typhoid fever, cerebro spinal meningitis, measles, membranous croup, so called, whooping cough occurring within the limits of its jurisdiction, and such notification shall be in accordance with the requirements of the blanks furnished by the said State board.

(4) Receive and examine into the nature of complaints made by any of the inhabitants concerning nuisances dangerous to life and health within the limits of its jurisdiction; enter upon or within any place or premises where nuisances or conditions dangerous to life and health are known or believed to exist, and personally, or by appointed agents, inspect and examine the same; and all owners, agents, and occupants shall permit such sanitary examinations; and every such board of health shall order the suppression and removal of nuisances and conditions detrimental to life and health found to exist within the limits of its jurisdiction.

(5) (As amended by ch. 130, acts of 1909). Make, alter, and amend such orders and by-laws as they shall think necessary and proper for the preservation of life and health and the successful operation of the health laws of the State, subject to the approval of any justice of the supreme judicial court. Notice shall be given by the board of health of all by-laws made or amended by them by publishing the same in some newspaper, if there is one published in such town; if there is none, then in the nearest newspaper published in the county; or by posting copies of said by-laws in six conspicuous and public places within the town; and a record of such publication, or posting, of said orders and by-laws in the office of the town clerk shall be deemed a legal notice to all persons.

[Revised Statutes, 1903, Chapter 4.]

SEC. 93. *Municipal sanitary powers.*— Towns, cities, and village corporations may make by-laws or ordinances, not inconsistent with law, and enforce them by suitable penalties for the purposes and with the limitations following:

(3) Respecting infectious diseases and health.

(4) For regulating the going at large of dogs.

(8) Respecting the erection of buildings therein and defining their proportions, dimensions, and the material to be used in the construction thereof, and any building erected contrary to a by-law or ordinance adopted under this specification is a nuisance.

(11) Cities may establish localities for and regulate the sale of fresh meat and fish therein and fix penalties for breach thereof.

(13) Cities may establish ordinances requiring all persons selling milk therein to be licensed, and may prescribe in such ordinances the terms and conditions upon which such licenses may be granted, when and how such licenses may be revoked and may prescribe penalties for violations of such ordinances. No person, unless so licensed, shall sell milk in any city where a license is required as herein provided.

MEMBERS OF THE MAINE MEDICAL ASSOCIATION*May 1, 1913.****ANDROSCOGGIN.**

Barrell, D. A., New Auburn.	Norton, C. E., Lewiston.
Beckler, W. B., Auburn.	O'Connell, G. B., Lewiston.
Bolster, W. W., Lewiston.	Peables, A. M., Auburn.
Call, Ernest V., Lewiston.	Peaslee, C. C., Auburn.
Cobb, A. A., Auburn.	Pennell, W. J., Auburn.
Cummings, E. S., Lewiston.	Philoon, C. E., Auburn.
Cushman, B. G. W., Auburn.	Pierce, E. F., Lewiston.
Dupras, J. E., Auburn.	Russell, E. W., Lewiston.
Edwards, M. O., Lewiston.	Scannell, J. W., Lewiston.
Emmons, Geo. P., Lewiston.	Sawyer, S. G., Lewiston.
Garcelon, A. M., Lewiston.	Sprague, O. A., Turner.
Garcelon, Harold, Lewiston.	Small, R. M., Auburn.
Gilbert, I. W., Litchfield.	Stevens, H. E. E., Lewiston.
Gerrish, L. P., Lisbon Falls.	Sleeper, H. S., Lewiston.
Hanscom, O. E., Greene.	Sturgis, B. F., Auburn.
Hawkins, W. N., Lewiston.	Wakefield, F. S., Lewiston.
Hayden, L. B., Livermore Falls.	Webber, W. E., Lewiston.
Irish, H. L., Turner.	Williams, C. E., Auburn.
McCarthy, H. T., Lewiston.	Wiseman, R. J., Lewiston.
Ness, Wm., Lewiston.	

AROOSTOOK.

Bates, E. C., Houlton.	La Fleche, L. P., Caribou.
Bennett, F. E., Presque Isle.	Larabee, F. F., Washburn.
Bigelow, F. F., Island Falls.	Libby, A. B., Smyrna Mills.
Boone, Sherman, Presque Isle.	Little, S. D., Caribou.
Chamberlain, W. G., Ft. Fairfield.	Mann, F. W., Houlton.
Damon, A. H., Limestone.	McNamara, W. F., Presque Isle.
Dickison, T. L., Houlton.	Mitchell, F. W., Houlton.
Doble, E. H., Presque Isle.	Porter, J. W. H., Caribou.
Dobson, H. L., Ashland.	Putnam, H. L., Houlton.
Ebbett, P. B. L., Hodgdon.	Potter, J. G., Houlton.
Field, E. H., Bridgewater.	Sawyer, A. D., Ft. Fairfield.
Flint, E. T., Foxcroft.	Sawyer, A. L., Ft. Fairfield.
Fraser, L. H., Westfield.	Schneider, G. H., Island Falls.
Fulton, A. J., Blaine.	Sincock, W. E., Caribou.
Gibson, W. B., Houlton.	Tarbell, F. W., Smyrna Mills.
Gilbert, Percy, Linneus.	Thomas, C. F., Caribou.
Haggarthy, A. B., Ashland.	Upton, Geo., Sherman.
Hammond, H. H., Van Buren.	Upham, R. C., Fort Kent.
Harmon, Chas. H., New Sweden.	Walker, A. G., Houlton.
Hill, F. O., Monticello.	Ward, P. M., Houlton.
Hunt, H. J., Island Falls.	White, W. W., Bridgewater.
Huggard, L. H., Limestone.	Williams, Chas. E., Houlton.
Jackson, F. H., Houlton.	Wilkinson, H. E., Eagle Lake.
Kilborn, Frank, Presque Isle.	

CUMBERLAND:

- Andrews, Egbert T., Gray.
Andrews, Anson H., Gray.
Abbott, E. G., Portland.
Allen, John H., Portland.
Alward, Mark, Portland.
Andrews, Eugene H., Brunswick.
Baldwin, Albert K., Portland.
Barrett, Felix, Cumberland Mills.
Bassford, S. J., Portland.
Bennett, J. L., Bridgton.
Blake, J. P., Harrison.
Bowers, J. W., Portland.
Bradford, W. H., Portland.
Bray, C. W., Portland.
Brock, H. H., Portland.
Brown, F. I., So. Portland.
Burr, Chauncey R., Portland.
Burrage, T. J., Portland.
Buzzell, L. C., Standish.
Carmichael, F. E., Portland.
Caswell, Chas. O., Portland.
Clough, D. J., Portland.
Conneen, T. F., Portland.
Connellan, J. W., Portland.
Cousins, W. L., Portland.
Cumston, C. H., Brunswick.
Davis, Gilman, Portland.
Drummond, J. B., Portland.
Davis, J. L., Portland.
Davis, P. W., Portland.
Derry, L. A., Portland.
Driscoll, Daniel, Portland.
Dunn, B. F., Portland.
Dyson, W. W., Portland.
Elliot, G. H., Brunswick.
Elwell, W. E., Portland.
Emery, H. E., Portland.
Everett, H. J., Portland.
Ferren, F. L., Westbrook.
Foss, C. W. P., Brunswick.
Files, E. W., Portland.
Fisher, S. E., Portland.
Folsom, E. B., Portland.
Foster, B. B., Portland.
Foster, Benj. B., Portland.
Foster, C. W., Woodfords.
Gardner, F. H., Portland.
Gehring, E. W., Portland.
Gerrish, F. H., Portland.
Gilbert, F. Y., Portland.
Gilson, Arthur S., Portland.
Gordon, S. C., Portland.
Gray, John E., Portland.
Hale, L. L., Chebeague Island.
Haney, O. E., Portland.
Hansen, Niels C., Portland.
Harper, I. D., No. Gorham.
Haskell, A. W., Portland.
Hatch, L. B., Portland.
Hersom, J. L., Portland.
Higgins, Leila, Portland.
Hills, L. L., Westbrook.
Holt, E. E., Portland.
Holt, E. E., Jr., Portland.
Horr, J. L., Westbrook.
Hubbard, C. P., So. Windham.
Hutchinson, Chas., Portland.
Hunt, C. H., Portland.
Jefferson, W. G., Portland.
Jordan, F. H., So. Portland.
King, Alfred, Portland.
Lamb, Frank W., Portland.
Leighton, A. P., Jr., Portland.
Leighton, C. M., Portland.
Lewis, Harriet M., Portland.
Lewis, W. J., Freeport.
Lewis, P. P., Gorham.
Little, A. H., Portland.
Lombard, H. A., Bridgton.
Marshall, N. M., Portland.
McDonough, E. J., Portland.
MacVane, E. F., Portland.
Milliken, H. E., Portland.
Mitchell, Alfred, Brunswick.
Mitchell, Alfred, Jr., Portland.
Moore, R. B., Portland.
Moran, Wm., Portland.
Moulton, O. C., So. Windham.
Moulton, H. M., Cumberland Center.
Moulton, W. Bean, Portland.
Moulton, W. B., Portland.
Murch, A. F., Cumberland Mills.
Nichols, Estes, Hebron.
Northcott, E. M., Portland.
O'Neill, Jas. B., Portland.
Palmer, C. A., Brunswick.
Parker, Chas. F., No. Windham.
Patterson, H. J., Portland.
Pingree, H. A., Portland.
Poor, L. H., Webbs Mills.

- Pudor, Gustav A., Portland.
 Reed, Asa P., Naples.
 Ridlon, C. H., Gorham.
 Robinson, E. F., Falmouth.
 Robinson, W. W., Portland.
 Rogers, J. K. P., Knightville.
 Sanborn, J. T., Portland.
 Searles, F. W., Portland.
 Shedd, G. H., No. Conway, N. H.
 Shedd, John, No. Conway, N. H.
 Smith, C. D., Portland.
 Smith, Owen P., Portland.
 Smith, T. P., Westbrook.
 Somers, P. E., Portland.
 Spalding, Jas. A., Portland.
 Straw, N. W. R., Portland.
 Stetson, E. G. A., Brunswick.
 Sturgis, John I., New Gloucester.
 Swasey, Geo. B., Portland.
 Sylvester, C. B., Harrison.
 Thayer, Addison S., Portland.
 Thayer, Augustus S., Portland.
 Thombs, S. B., Portland.
 Thompson, W. S., Standish.
 Thompson, John F., Portland.
 Thompson, P. P., Portland.
 Tobie, Walter E., Portland.
 Twitchell, H. F., Portland.
 Vaughn, P. H. S., Yarmouth.
 Warren, Stanley P., Portland.
 Webber, M. A., Portland.
 Webber, M. C., Portland.
 Webster, F. P., Portland.
 Weeks, A. H., Portland.
 Welch, F. J., Portland.
 Whitmore, Wm., Portland.
 Whittier, F. N., Brunswick.
 Williamson, W. D., Portland.
 Witham, A. N., Westbrook.
 Witherle, C. B., Portland.
 Woodman, D. N., Yarmouthville.

FRANKLIN.

- Blanchard, W. I., Phillips.
 Brown, E. J., Stratton.
 Colby, F. B., Rangeley.
 Currier, E. B., Phillips.
 Head, O. B., New Sharon.
 Howard, A. G., Farmington.
 Hopkins, P. O., New Portland.
 Makepeace, B. F., Farmington.
 Nichols, J. W., Farmington.
 Pennell, E. L., Kingfield.
 Perkins, J. W., Wilton.
 Pratt, Geo. L., Farmington.
 Presson, Dorris M., Farmington.
 Ross, A. M., Rangeley.
 Sanborn, W. B., Augusta.
 Trefethen, W. J., Wilton.
 White, V. O., East Dixfield.
 York, A. J., Wilton.

HANCOCK.

- Black, R. A., Sullivan.
 Bragg, J. S., Gouldsboro.
 Gage, J. B., Atlantic.
 Hagerthy, A. C., Ellsworth.
 Hagerthy, G. R., Bar Harbor.
 Higgins, R. S., Bar Harbor.
 Hodgkins, Lewis, Ellsworth.
 Holt, H. A., West Sullivan.
 Hutchins, J. G., Stonington.
 Littlefield, O. A., Bluehill.
 Larabee, C. C., Gouldsboro.
 Morrison C. C., Bar Harbor.
 Morrison, E. J., Bar Harbor.
 Neal, J. A., Southwest Harbor.
 Ober, F. R., Northeast Harbor.
 Patten, J. H., Bar Harbor.
 Phillips, G. A., Bar Harbor.
 Phillips, J. D., Southwest Harbor.
 Smith, F. Fremont, Bar Harbor.
 Tapley, Thos., McKinley.
 Underhill, C. S., Sullivan.
 Wakefield, R. W., Bar Harbor.
 Wardwell, M. A., Penobscot.
 Webster, H. B., Castine.
 Woodruff, H. L. D., Ellsworth.

KENNEBEC.

- Abbott, C. W., Waterville.
 Abbott, H. W., Waterville.
 Barrows, H. C., Boothbay Harbor.
 Beane, C. H., Hallowell.
 Beach, S. J., Augusta.
 Boyer, E. W., Waterville.
 Bunker, L. G., Waterville.
 Campbell, G. R., Augusta.
 Chenery, F. L., Wayne.
 Coombs, G. A., Augusta.
 Cragin, D. B., Waterville.
 Daveis, O. C. S., Augusta.
 Donnell, R. E., Gardiner.
 Downs, A. A., Fairfield.
 Fish, E. P., Waterville.
 Fletcher, A. S., Waterville.
 Frederick, H. J., Augusta.
 Goodrich, E. E., Waterville.
 Goodrich, Matthew, Waterville.
 Harris, W. H., Augusta.
 Hall, H. W., Augusta.
 Hardy, T. E., No. Vassalboro.
 Hedin, Carl J., West Pownal.
 Hill J. F., Waterville.
 Horsman, H. L., Augusta.
 Hurd, B. P., Waterville.
 Johnson, H. L., Augusta.
 Johnson, Wellington, Augusta.
 Leach, C. H., South China.
 Libby, A. B., So. Gardiner.
 Lincoln, C. I., Augusta.
 Mabry, Chas., No. Vassalboro.
 Mann, L. L., Augusta.
 McKay, R. L., Augusta.
 Merrill, P. S., Waterville.
 Miller, H. W., Augusta.
 Milliken, H. A., Hallowell.
 Nutting, J. D., Jr., Hallowell.
 Newcomb, C. H., Clinton.
 Odiorne, J. E., North Whitefield.
 Parker, Geo. C., Winthrop.
 Pitman, M. W. H., Bowdoinham.
 Ridlon, B. D., Togus.
 Roy, L. O., Augusta.
 Sampson, H. W., Togus.
 Sawyer, Alton, Gardiner.
 Shaw, A. A., Clinton.
 Simons, Ralph, Gardiner.
 Small, Morton, Weeks Mills.
 Strout, F. E., Gardiner.
 Stinson, H. K., Togus.
 Stubbs, R. H., Augusta.
 Sturgis, Karl B., Augusta.
 Sturdivant, A. H., Augusta.
 Thayer, F. C., Waterville.
 Totman, V. S., Oakland.
 Towne, J. G., Waterville.
 Washburn, Geo., Augusta.
 Witherall, C. H., Oakland.
 Young, A. G., Augusta.

KNOX.

- Adams, F. B., Rockland.
 Alden, Eben, Rockland.
 Bartlett, F. O., Rockland.
 Coombs, G. H., Waldoboro.
 Campbell, Fred, Warren.
 Foss, A. W., Rockland.
 Frohock, H. W., So. Thomaston.
 Gribben, H. E., Rockland.
 Hadley, L. W., Union.
 Hart, W. F., Camden.
 Huse, B. D. L., Camden.
 Judkins, M. P., Rockland.
 Kellar, B. H., Appleton.
 Lyford, W. F., Vinalhaven.
 North, C. D., Tenant's Harbor.
 O'Connor, M. J., Rockland.
 Silsby, E. B., Rockland.
 Spear, W. M., Rockland.
 Stuart, Carleton, Rockport.
 Walker, E. J., Thomaston.
 Weidman, S. Y., Rockport.

OXFORD.

- Allen, George A., Lovell.
 Barker, F. N., Norway.
 Bicknell, Ralph, Canton.
 Bartlett, H. L., Norway.
 Binford, H. J., Mexico.
 Bradbury, B. F., Norway.
 Bisbee, C. M., Rumford Falls.
 Cobb, J. J., Berlin, N. H.
 Farris, H. R., Oxford.
 Gehring, J. G., Bethel.

Haskell, W. B., Oxford.
 Hutchins, G. H., Mechanic Falls.
 Heald, H. M., Buckfield.
 Hutchins, W. P., Rumford Falls.
 Leslie, F. E., Andover.
 Littlefield, J. G., So. Paris.
 Lougee, A. J., Fryeburg.
 McCarty, E. M., Rumford Falls.
 Nile, J. Abbott, Rumford.
 Pease, W. M., Dixfield.
 Snell, F. W., So. Paris.

Stanwood, A. L., Rumford Falls.
 Stewart, D. M., So. Paris.
 Stimpson, A. J., Waterford.
 Sturdivant, Jas. S., Dixfield.
 Tibbets, R. R., Bethel.
 Trufant, L. H., Norway.
 Wheeler, F. E., W. Paris.
 Wheet, F. E., Rumford Falls.
 Wight, I. H., Bethel.
 Wilson, Chas. E., Hiram.

PENOBSCOT.

Bates, Willard A., Enfield.
 Bayard, C. H., Orono.
 Brown, A. A., Bangor.
 Brown, E. E., Bangor.
 Bryant, B. L., Bangor.
 Bryant, Chas. S., Millinocket.
 Bunker, David, Bangor.
 Burgess, Chas. H., Bangor.
 Calvin, C. M., Brewer.
 Caulfield, G. B., Bangor.
 Chapman, H. M., Bangor.
 Clough, H. T., Bangor.
 Coe, T. V., Bangor.
 Crane, H. H., Bangor.
 Edmunds, C. D., Bangor.
 Elkins, P. H., Old Town.
 Ellingwood, Wm., Winterport.
 Emerson, O. R., Newport.
 Farnham, E. J., Patten.
 Fitz-Morris, T. J., Bangor.
 Freeman, F. H., Surry.
 Hall, Leo F., Wynn.
 Hennessy, Daniel, Bangor.
 Hills, F. H., Bangor.
 Hunt, W. L., Bangor.
 Howes, L. M., Bangor.
 King, H. A., Bangor.
 Lethiecq, J. A., Brewer.
 Love, R. J., Danforth.
 Landry, G. E., Old Town.
 Madden, M. C., Old Town.
 McCann, Daniel, Bangor.

Mansfield, Blanche, Bangor.
 Marquis, L. M., Old Town.
 Mason, W. C., Bangor.
 Mason, L. S., Bangor.
 McNally, W. P., Bangor.
 Milliken, H. J., Bangor.
 Murphy, T. J., Bangor.
 Nason, C. J., Bangor.
 Nason, W. H., Hampden.
 Nealey, E. T., Bangor.
 Peters, W. C., Bangor.
 Redman, S. J., Exeter.
 Richardson, H. K., Bradford.
 Robinson, D. A., Bangor.
 Robinson, Lewis, West Pownal.
 Russell, James P., South Brewer.
 Sawyer, E. B., Bangor.
 Sanger, E. B., Bangor.
 Simmons, W. H., Bangor.
 Smith, A. K. P., Corinna.
 Starett, J. F., Bangor.
 Thomas, C. P., Brewer.
 Thompson, H. E., Bangor.
 Tibbetts, G. B., Orrington.
 Tomlinson, Edw., Orono.
 Twitchell, A. W., Old Town.
 Tyson, F. C., Bangor.
 Warren, Percy, Bangor.
 Weld, G. G., Old Town.
 Whitney, W. E., Bangor.
 Woodcock, Galen, Bangor.
 Woods, J. B., Bangor.

PISCATAQUIS.

Brown, A. A., Monson.
 Brown, M. O., Foxcroft.
 Bumps, W. A., Dexter.
 Cowie, Wm., Guilford.
 Crosby, N. H., Milo.

Ford, L. C., Milo.
 Hall, C. C., Dover.
 Hathaway, W. R. J., Milo.
 Hunt, Hiram, Greenville.
 McFayden, James, Milo.

Marsh, R. H., Guilford.
 McDonough, F. H., Brownville.
 Merrill, E. D., Foxcroft.
 Potter, J. L., Guilford.
 Pritham, F. J., Greenville Jct.

Ray, C. W., Sangerville.
 Snow, H. A., Milo.
 Stanhope, A. H., Dover.
 Schriver, A. E., Milo.
 Wilson, J. H., Cambridge.

SAGADAHOC.

Barker, Byron, Bath.
 Donnell, R. H., Bath.
 Fox, H., Bath.
 Fuller, Edwin, Jr., Bath.
 Fuller, Edwin, Bath.
 Gregory, G. A., Boothbay.
 Hannigan, R. E., Bath.
 Irish, I. C., Bowdoinham.

Lincoln, Jos. O., Bath.
 Marston, E. J., Bath.
 Peabody, F. B., Richmond.
 Peaslee, C. A., Bath.
 Price, W. N., Richmond.
 Snipe, L. T., Bath.
 Stott, A. A., Bath.
 Williams, A. F., Phippsburg.

SOMERSET.

Ames, J. D., Norridgewock.
 Caza, O. J., Skowhegan.
 Dascomb, L. A., Skowhegan.
 Milliken, W. S., Madison.
 Moulton, C. A., Hartland.
 Porter, E. A., Pittsfield.
 Robinson, F. J., Fairfield.
 Sawyer, W. G., Madison.

Smith, H. W., Norridgewock.
 Stinchfield, W. S., Skowhegan.
 Taggart, H. C., Skowhegan.
 Tash, T. P., Fairfield.
 Tozier, F. L., Fairfield.
 Wadsworth, J. E., Skowhegan.
 Wing, E. M., No. Anson.

WALDO.

Cook, N. R., Brooks.
 Hoyt, C. B., Liberty.
 Johnson, S. W., Belfast.
 Kilgore, A. E., Brooks.
 Kilgore, G. C., Belfast.
 Millett, Adelbert, Belfast.

Small, E., Belfast.
 Stevens, E. L., Belfast.
 Vickery, O. S., Belfast.
 Whitney, C. M., Unity.
 Wilson, E. A., Belfast.
 Wood, Harold A., Belfast.

WASHINGTON.

Barker, N. B. T., Woodland.
 Bennett, E. H., Lubec.
 Best, H. B., Pembroke.
 Bunker, W. M., Calais.
 Burritt, G. L., Harrington.
 Crain, J. W., Dennysville.
 Cranston, E. A., Calais.
 Dienstadt, W. W., St. Stephen, N. B.
 Gilbert, W. G., Calais.
 Grady, Eliza, Eastport.
 Gray, W. Everett, Milltown, N. B.
 Hambelton, M. P., West Jonesport.
 Holland, R. A., Calais.
 Johnson, C. E., Princeton.
 Johnson, H. O., Machias.
 Johnston, L., Vassalboro.
 Larson, O. F., Jonesport.

Longfellow, J. W., Machias.
 Main, C. C., St. Stephen, N. B.
 Mason, H. B., Calais.
 Murry, A., Lord's Cove, Deer Isle, N. B.
 Miner, W. N., Calais.
 Murphy, J. L., Eastport.
 Porter, M. L., Danforth.
 Smith, A. L., Machias.
 Smith, J. R. N., Milltown.
 Shaw, F. L., Machias.
 Sullivan, E. V., St. Stephen, N. B.
 Tustin, Ruth, Eastport.
 Walling, J. A., Millbridge.
 White, E. A., Columbia Falls.
 Webber, S. E., Calais.
 Young, M. L., Oak Bay, N. B.

YORK.

Abbott, Percy H., Goodwin's Mills.	La Rochelle, J. R., Biddeford.
Blagdon, C. W., Sanford.	Lander, E. E., Alfred.
Brown, L. H., No. Berwick.	Lord, F. C., Kennebunk.
Burnham, E. L., Sanford.	Maynard, A. C., Biddeford.
Black, L. M., Saco.	McCorrison, J. O., No. Berwick.
Butler, J. D., Newmarket.	Moulton, B. M., Springvale.
Carpenter, L. W., Limerick.	O'Neil, E. D., Biddeford.
Carty, J. D., Kittery Point.	O'Connor, J. M., Biddeford.
Cochrane, J. D., Saco.	Parady, L. W., Springvale.
Cook, E. P., York Village.	Pillsbury, C. W., Saco.
Davis, F. L., Biddeford.	Powell, L. L., Saco.
Davis, A. S., Maplewood.	Prescott, H. L., Kennebunkport.
Dolloff, D. E., Biddeford.	Precourt, G. C., Biddeford.
Durgin, H. I., So. Eliot.	Purington, H. H., Kennebunk.
Elliott, W. T., Berwick.	Randall, J. A., Old Orchard.
Emery, C. J., Biddeford.	Ross, F. M., Kennebunk.
Ferguson, M. H., Biddeford.	Shapleigh, E. E., Kittery.
Girard, L. A., Biddeford.	Small, F. E., Biddeford.
Goodale, W. T., Saco.	Smith, F. W., York Village.
Gove, R. S., Sanford.	Smith, W. W., Ogunquit.
Hill, P. S., Biddeford.	Thompson, C. E., Saco.
Hill, S. C., Sanford.	Traynor, C. F., Biddeford.
Hobbs, F. H., So. Waterboro.	Weymouth, H. A., Saco.
Hurd, H. Willis, Biddeford.	Wentworth, B. F., Scarboro.
Jones, A. L., Old Orchard.	Wentworth, D. W., Sanford.
Kelly, W. H., Sanford.	Wiley, A. G., Bar Mills.
Kendall, C. F., Biddeford.	Willard, L. E., Saco.
L'Heureux, J. N., Sanford.	Willis, J. L. M., Eliot.

*This list of members consists of those reported as in good standing by the Secretaries of the County Societies at the June, 1912, meeting and does not cover all changes made during the year, as the reports for 1913 have not been received.

Book Reviews.

Safeguarding the Special Senses.

By Dr. Henry O. Reik, Baltimore. Published by F. A. Davis & Co., Philadelphia. Price \$1.25.

This very interesting and valuable book for the laity and for public school use is made up from lectures delivered by Dr. Reik, an eminent specialist in diseases of the eye, ear, nose and throat. The author tells his readers how they overuse their eyes, neglect their ears, and foolishly medicate their noses and throats. Prevention is the motive of the book. It is neat to handle, printed in excellent type on paper free from gloss, and is admirable for use in our schools. A few illustrations, such as one showing the proper way in which to instil a lotion into the eye, and another depicting diseased tonsils and adenoids add value as means of instruction. The italicizing of impor-

tant suggestions gives teachers a clue to proper points to be emphasized to pupils.

I wish that every physician would reflect on that part of a lecture on the throat in which the author advocates enucleation of the tonsil, urges that the operation is a capital operation, and insists that the patient should be carefully kept under observation for a week. For the present-day method of permitting tonsilectomy patients to leave observation on the day following an operation or even in forty-eight hours, *belittles the surgeon's skill and his fee*, and subjects the patient to unjustifiable risks. I commend Dr. Reik's handy volume most highly, and can only wish that I had thought to have written it myself.

J. A. S.

*Program of Maine Medical Association, June 25-26, 1913

Treatment of Compound Fracture.

(Symposium.)

Conservative Treatment,

Hiram Hunt, Greenville

Radical Treatment,

W. C. Peters, Bangor

The Treatment of Fractures with Lane Plates,

A. D. Sawyer, Fort Fairfield

Radiography,

F. W. Lamb, Portland

Lateral Curvature,

E. G. Abbott, Portland

Knee Joint Surgery with Lantern Slide Illustrations,

W. R. MacAusland, Boston

"The Etiology of Goitre,"

F. E. Leslie, Andover

"Prophylaxis in the Army,"

Wm. H. Wilson,

Major Medical Corps, U. S. Army, Ft. McKinley

The Eye as Affected by Constitutional Diseases,

J. A. Spalding, Portland

Annual Oration, "Typhoid Fever,"

David L. Edsall, Boston

Artificial-Pneumothorax,

F. J. Welch, Portland

The Alcoholic Psychoses,

F. C. Tyson, Bangor

Latest Laboratory Tests which are of Value in Diagnosis,

F. N. Whittier, Brunswick

Heroin Addiction:—

Resume of the Literature, with Reported Cases,

Paul K. Sellew, Brookline, Mass.

***Notice.**—The Entertainment Committee of Cumberland County Medical Society are making special effort to provide entertainment for the visiting doctors, wives and families during the two days' stay.

Some entertainment for the ladies will be provided for Wednesday afternoon, while on Wednesday evening they will be invited to attend the annual banquet.

On the morning of Thursday, some plan of entertainment will be arranged for, while in the afternoon arrangements are in progress with the view of giving them a sail down the bay previous to the clam bake.

Every effort will be made to give the visiting ladies an exceptionally good time. On the other hand, if the attendance is not sufficiently large to warrant continuing this plan, it will not be tried again. Better make this a family vacation and we will promise you a good time.

Address all communications relative to entertainment, hotel accommodations, etc., to Dr. H. J. Everett, 727 Congress St., Portland, Me.

Case Reports.

Is This Pellagra?

CASE I. Adult male, 42 years old. Tall, muscular, and of the laboring class. Sandy complexion.

Called at my office in April, 1910, with complaint of feeling tired, having dizzy head and digestive trouble. He was doing hard farm work at that time, and had been at work all winter.

The kidneys, heart and lungs were normal. The skin on face, neck, hands and forearms was of an angry red color. An apparent sunburn, yet of a most intense grade and coming at a time when sunburn does not appear normally, as the snow had gone.

In response to questioning, the patient stated that this was the third consecutive spring the symptoms and erythema had appeared.

A few months later this man died while under care of another physician and after a period of acute and violent mania. The death certificate gave tubercular meningitis as cause of death.

CASE II. Girl, nine years old. Well nourished, though of below normal height and weight for her age, as her younger sister equals her in size. Her mother brought her to my office from a neighboring town for treatment for sunburn of the face, hands and exposed parts of the arms and neck, recurring this spring for the third time. This time in March, the two other times in May. May, June and July being the worst months, the condition clearing up in the late summer and fall.

There was apparent to me a deep erythema, very surprising in view of the fact that the child wore a heavy dark veil.

The mother stated this had proceeded the two previous years to blistering, scabbing and pustulation, in spite of treatment and protection from exposure. She also said the child had, at times, double vision, but no error of refraction.

To me she presented the appearance of an old person in her facial expression. Her gait was uncertain and she took especial care going down steps. The family had noticed a muscular weakness of the legs, and at one time she had come home on all fours on that account. She has, lately, become backward in school matters.

This erythema may possibly be due to a personal idiosyncrasy to the effects of the sun's rays, but, if so, why does it always manifest itself only in certain months, and at a time when sunburn is not common, and exposure to the sun not severe. I have seen as deep a burn after prolonged exposure on the salt water as existed in the first case. I never have seen, however, any such thing as the mother describes as occurring to her daughter, even protected carefully as she was.

My limited chance to examine these cases renders this report defective, but the peculiar erythema alone is, it seems to me, worth the space.

H. J. HUNT, M. D., ISLAND FALLS, ME.

County News.

CUMBERLAND.

The regular meeting of the Cumberland County Medical Society was held the evening of April 19th at the Congress Square Hotel. The speaker of the evening was Dr. William Seaman Bainbridge of New York City, a prominent surgeon whom those of the members who attended the Surgical Congress at New York last fall followed with interest from clinic to clinic. His subject for the evening was "Chronic Intestinal Stasis," a paper which he had to cut greatly on account of the brevity of the time allowed him, and which was listened to with the greatest interest by all those present. The author presented in a most graphic manner, aided by stereopticon pictures of X-Ray plates, and actual photographs and drawings, all the newly discovered anatomical peculiarities that are being pointed to by Lane as causes for many abdominal ills, and brought home to his auditors by citation of case after case operated upon and relieved, the fact that the responsibility has been well fixed upon these peculiar abdominal conditions. Dr. Bainbridge is a most interesting and forceful speaker, and imparted his enthusiasm in a most pleasing way.

At the business meeting the report of the Legislative Committee was read and accepted. The committee of entertainment for the Maine Medical Association was appointed to consist of Drs. Pudor, Everett and Drummond.

A Dutch lunch followed completion of the business.

H. J. EVERETT, *County Editor.*

PORTLAND MEDICAL CLUB.

The fourth meeting of the year was held at the Columbia Hotel, April 3rd, with thirty members present. It was voted to amend the constitution of the club to provide for a Calling Committee of three members. Dr. Gordon, who was present as a guest, reported the failure of the Legislature to pass the bill making osteopaths take the regular examination before the State Board of Registration in medicine.

Dr. Fisher reported a case of secondary tonsillar hemorrhage, occurring five days after tonsillectomy, and finally checked by suturing the pillars of fauces. Dr. Hatch reported a case of hemorrhage of the new-born, occurring in the child of the woman whom she had reported at the last meeting as having had nutmeg poisoning during her pregnancy. The hemorrhage was checked by the injection of 15 cc. of rabbit serum on two successive days.

The paper of the evening was by Dr. Adam P. Leighton, Jr., his subject being "The Conservative Treatment of Eclampsia." After citing opinions from the leading obstetricians of this country to show that they are almost unanimously in favor of prompt evacuation of the uterus as a first step in the treatment of eclampsia, the essayist quoted statistics from various sources to prove that the mortality ob-

tained by these men is much greater than that resulting where the so-called Stroganoff or morphine treatment is used. The technique of the latter treatment was then given in detail, as applied at the Rotunda Hospital in Dublin. The paper proved to be of great interest to all present, and aroused a lively discussion in which most of the members took part.

R. B. MOORE, *Secretary*.

KENNEBEC.

The quarterly meeting of the Kennebec County Medical Society was held in the evening, March 28th, 1913, at the Augusta House, Augusta. Thirty members were present. After an excellent Dutch lunch, served by landlord Emerson, the Society listened to a paper on "Cerebral Surgery" by Dr. E. H. Nichols of Boston. The address was supplemented by many excellent original drawings, and was well received.

H. W. MILLER, *Secretary*.

YORK.

The 72d quarterly session of the York County Medical Society was held at the Webber hospital, Biddeford, Thursday, April 3d. Dr. L. E. Willard of Saco presided. The records of the January meeting were read and approved. Drs. S. B. Marshall of Alfred and F. E. Phillips of Wells were elected members. Two other applications were referred to the Board of Censors. It was voted to address a letter to the Biddeford city government, recommending the appointment of a physician as a member of the Biddeford Board of Health. Cape Porpoise was selected as the place for the summer outing in June.

An excellent dinner was provided by the superintendent of the hospital, Miss Matthews, and the nurses. As a token of appreciation, the sum of \$25 was collected and donated for the purpose of purchasing articles needed in the nurses' home.

Dr. H. F. Twitchell read a paper, "Fee, Friction and Function of the Surgeon." He also gave a demonstration of the use of cystoscope. Votes of thanks were extended to Dr. Twitchell and the Webber Hospital Association for their efforts in making the meeting a successful one.

There were present: Drs. L. E. Willard, C. E. Thompson, L. L. Powell, C. W. Pillsbury, J. D. Cochrane, J. D. Haley, Laura M. Stickney, Saco; C. J. Emery, M. H. Ferguson, J. M. O'Connor, P. S. Hill, F. L. Davis, C. F. Kendall, C. F. Traynor, D. E. Dolloff, L. A. Girard, A. C. Maynard, Grace E. Wheaton, Biddeford; H. H. Purinton, Kennebunk; H. L. Prescott, Kennebunkport; J. W. Gordon, Ogunquit; E. C. Cook, York Village; C. E. Hander, Alfred; W. E. Hightle, No. Berwick; P. H. Abbott, Goodwins Mills; C. W. Blagden, J. N. L'Heureux, Sanford; B. M. Moulton, L. W. Parady, Springvale; B. F. Wentworth, West Scarboro; J. A. Randall, A. L. Jones, Old Orchard; H. F. Twitchell, Portland. Other guests were Messrs. D. T. Moore, clerk of the Hospital Association; C. R. Gould, P. S. Sullivan, Biddeford, and C. G. Dennett, Saco, students in the Maine Medical School.

ARTHUR L. JONES, *Secretary*.

WASHINGTON.

The April Meeting of the Washington County Medical Society will be held in Eastport. W. N. MINER, *Secretary*.

Personal News and Notes.

Dr. H. B. Mason, one of our oldest and best known physicians in this part of the county, is quite ill at the Chipman Memorial Hospital. We hope for his speedy recovery.

The new wing on the Chipman Memorial Hospital is about completed. This means an addition of twenty-four private rooms, which will partially meet the demand for the same during the past year.

Prof. John Lovett Morse of Harvard, specialist on the diseases of children, lectured before the Parent Teacher's Association to a crowded house on last Friday evening. He also spoke to the physicians and others at the home of Dr. S. E. Webber during that afternoon. It is needless to say that both lectures were favorably received, containing as they did much valuable information along scientific lines.

Dr. N. B. T. Barker, who has been away for a few weeks' vacation, has returned. During his visit, his practice was looked after by Dr. Ross of Brunswick.

Dr. H. E. Milliken of Portland, who is doing Post Graduate work in Europe, was recently elected Orientationist or Chairman of the Section on Internal Medicine and Neurology of the American Medical Association of Vienna.

The Fifteenth Annual Meeting of the American Proctologic Society will be held in Minneapolis, Minn., June 16 and 17, 1913. Headquarters and place of meeting, Hotel Radisson, Seventh Street near Nicolet Avenue. The profession is cordially invited to attend all meetings. Lewis H. Adler, Jr., Philadelphia, Pa., *Secretary*.

At a meeting of Alienists and Neurologists of the United States held in Chicago, April 17, 18, 19th, 1912, under the auspices of the West Side Branch of the Chicago Medical Society and the Chicago Medical Society, a resolution was adopted to hold a second meeting in Chicago in 1913, and a committee to be appointed to arrange for such a meeting. In accordance with the resolution, such a committee has been appointed, with Dr. H. N. Moyer, Chicago, Chairman and Dr. W. T. Mefford, Chicago, *Secretary*.

Drs. John F. Thompson and John Allen of Portland have sailed for Europe on a six weeks' trip.

The Libby Memorial Hospital at Waterville, which has been successfully conducted for the past two years by Drs. E. W. Boyer, and Donald B. Cragin, was transferred by them on May 1st to the Sisters of Charity, whose head house is at St. Joseph's College, Emmettsburg, Md. This same sisterhood has charge of the Carney Hospital in Boston, and it is proposed to enlarge the Libby Hospital, so as to provide wards for free patients.

Dr. T. E. Hardy who has practiced for a number of years at North Vassalboro, will remove on July 1st to Waterville.

Dr. Samuel H. Kagan from Boston, Mass., has opened an office at Augusta.

Drs. H. J. Frederick and C. J. Lincoln of Augusta, with Dr. A. B. Libby of South Gardiner, will sail for Europe at the end of June, for a trip of about two months, part of which will be spent in the London hospitals.

Dr. R. D. Simons of Gardiner, sailed for Europe, last month, to attend clinics in Berlin, Paris and London.

Dr. A. B. Libby, who has practiced for some years in South Gardiner, now has an office in Gardiner as well, in the house formerly occupied by the late Dr. W. B. Giddings.

Dr. G. W. Alexander has removed from Orono to Gardiner.

Dr. H. L. Shapleigh, who has practiced for some years in Boston, Mass., is now located in Lewiston, Maine.

Dr. W. H. Chaffee, who has lately returned from Paris, has opened an office in Lewiston, where he limits his practice to the eye, ear, nose and throat.

Dr. H. Taylor is practicing in Orono in the place of Dr. G. W. Alexander.

Dr. Charles W. Price of Richmond, passed away at his home, April 26th, 1913, following an illness that had confined him to his home for the past five or six weeks. He was a member of the Maine Medical Society, Maine Academy of Medicine and Science and the American Medical Association.

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JUNE, 1913.

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Members should notify the editor of any change in address, also notify him of failure to receive copy of the Journal.

Notice from members regarding sale of practice, merchandise, etc., should be sent in early and specify the number of insertions.

All news items, case reports, etc., must be had by the 15th, for insertion. Papers are published in order of their being received, with the exception of State papers which take precedence.

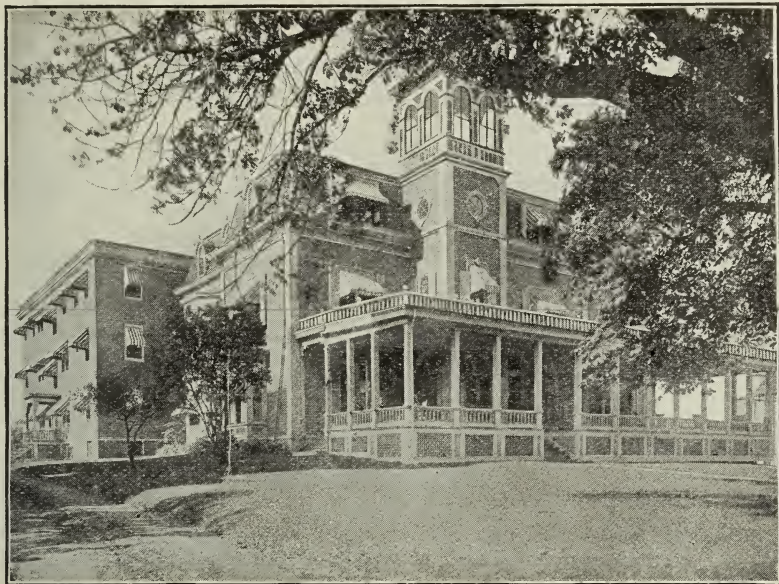
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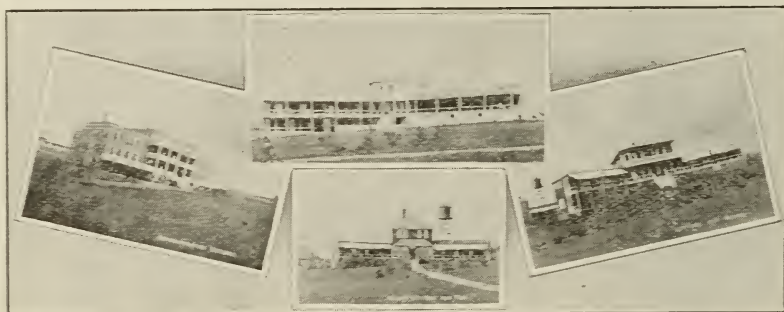
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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. III.

JUNE, 1913.

NO. II

PROBLEMS OF OBSTETRICAL PRACTICE.

By DR. W. W. CHIPMAN OF MONTREAL.

Read before Penobscot County Medical Society.

It was in 1850 that Dr. James P. White of Buffalo inaugurated clinical methods of teaching in obstetrics, so that in America practical instruction in this great art is some seventy-two years old.

During this three-quarters of a century, the report is one of progress, great progress both in our knowledge and in our skill, nevertheless, obstetrics today still deserves but a small measure of congratulation. In the great race of progress it continues to run a bad third with medicine and surgery.

Assuredly parturition is rightly enough to be regarded as a physiological process, in Sir Halliday Croom's telling phrase, "a physiological process identical in the countess or in the cow," but its results in death and disablement render it frequently of the nature of a pathological calamity. The price of motherhood is still cruelly high. And though a part of this high price may be charged to the depraved social conditions of luxury and indolence, poverty and over-work, to social wear and tear, by far the larger share must be underwritten by the medical profession. Who but ourselves are to blame if in Canada and the New England States some five hundred women each year die in childbed, and some five thousand more are therein more or less

permanently disabled, when we remember that a full three-quarters of this number are the victims of a septic infection, so often the technical euphemism for medical carelessness or neglect. Where practice is admittedly ignorant or imperfect the training is, without question, at fault. Let us frankly acknowledge it, that the fault in the practice of obstetrics is with our teaching, or our want of teaching. In part, I exonerate too the teachers for this subject, for obvious reasons, is extremely difficult to teach.

Accordingly, it is no surprise that barely one-half of our hundred and twenty medical schools are pronounced as "acceptable" by a tribunal composed of ourselves; and of this half, namely sixty, a mere six are admittedly possessed of adequate clinical training in obstetrics.

A recent and brilliant graduate of one of Canada's leading schools informed me that his practical training as a midwife consisted in observing two normal deliveries at a distance of ten feet; and that his post-graduate course in the same subject at one of your pre-eminent schools, was embodied in watching twelve such cases from a similar distance. Admirably trained was this man, but not as an obstetrician, rather as an observer. And with such an instance in our minds there may be some truth in the boast of the surgeon that in America it is safer to have one's abdomen opened for any chronic condition than it is to bear a child. Be this as it may it is true, I think, that brilliant surgical achievements have blinded our academic vision—our general vision—as to what is the student's greatest need in the general practice of his profession. To the average student, obstetrics is perhaps the subject of greatest importance. And it were almost better, I sometimes think, if so-called classic surgery were banished altogether from our undergraduate curriculum.

In the "Journal of the Medical Association" of January of this year appeared an article entitled, "The Management of Normal Labour." I, for one, feel very glad that this article was written, for it has done so much to show us to ourselves. The article, you remember, professes to set forth simple rules of procedure in a case of normal labour. In all charity it seems to me that one may surely designate its technique as careless, and characterize repeated vaginal examinations, the pushing up of the cervix over the descending head, and the delivery of a refractory placenta by even gentle traction on the cord or by grasping its lower edge, as "meddlesome midwifery." And yet these are the procedures which the article, somewhat officially, advocates. Throughout its pages internal examinations and manipulation are regarded far too much as a routine, and a matter of course; and this, it seems to me, is dangerous teaching.

I propose this evening to submit to you our teaching position in McGill University in respect of one or two problems of obstetrical practice. The only virtue that we can claim is that we recognize the inadequacy of our clinical teaching and are striving in every way to remedy it.

The first problem is just this one before-mentioned, the management of normal labour, the oldest problem, the commonest, and the most important. I have preferred the term "The Problem of Spontaneous Parturition," as wider and more comprehensive, since the proper conduct of a normal labour should begin long before the onset of the labour pain. A good obstetrician should be wise before the event, and not alone at the actual crisis. It is not enough that he should go when he is sent for "when the woman expects to be in labour," to use the words of the Journal's article, but he should go to all his *booked* cases unsolicited, some six weeks before this time.

I. The Problem of Spontaneous Parturition.

As I have already intimated, the proper solution of this problem demands a careful examination of the pregnant woman some four or six weeks before the date of her confinement. If this is true in all cases, it is particularly true in women gravid for the first time. To omit such an examination in primiparæ is a sin of gross carelessness, no matter how busy the practitioner, or how humble the patient.

The routine examination at such a time, say at the seven and a half month, is to include (a) a careful palpation of the abdomen, to determine the size of the child, the presenting part and its position; (b) the measurement of the pelvis, notably that of its external conjugate or Baudeloeque's diameter, and the transverse diameter of the outlet. 19 cm should be graven upon the first diameter, and 1 cm upon the second, as anything short of these means trouble in delivery. At the same time, it is wise to palpate the depth and inclination of the pubic arch, in selected cases to verify the health of the vulva and urethra, and always to ascertain the condition of the nipples and breasts.

No internal examination need be made, provided that all normal conditions are satisfied. If there is any doubt the diagonal conjugate should be measured. There are here three outstanding rules:

(1) In primiparæ, when the head presents, it must at this time lie low in the pelvis, well engaged in the upper strait.

(2) In the breech presentation leave it alone, or as they have it North of the Tweed, "For God's sake leave it be."

(3) Do not forget the urine. Each week it is to be examined in its specific gravity, and for albumen and sugar.

And now, when labour calls, the physician goes forearmed. Sterile rubber gloves and a gown, at least fresh laundered, are not only wise but essential; so, for the patient is a general bath, a soapsuds enema, and a shaving of the vulva hair. The physician, by abdominal palpation, ascertains whether or no labour has begun, estimating by the sense of touch the strength of the uterine contraction; he rehearses in the same way the presentation and position of the "passenger." The location of the foetal heart assists in this, and its rhythm indicates the vitality, if scarcely the sex of the child.

No further examination is at this time desirable. If, however, the first stage be prolonged, the condition of the cervix, and the degree of dilation of the os, may be ascertained, per rectum, by the gloved finger. This necessitates, however, a second pair of gloves.

In normal labour, rupture of the membranes usually coincides with the full dilation of the cervical canal. When this occurs, a careful vaginal examination may be made; its object is to ascertain if the cord, or any foetal member be prolapsed, and to learn the position and likely mechanism of the presenting part. In primiparæ, where the presenting part has been from the first well engaged, this examination can safely be withheld. Such an examination means an entrance for the first time upon the field of operation, and it should always be fearfully undertaken, not as the fool who rushes in but as the fearful angel. The vulva and vulvar slit are cleansed with soap and water, and the free use of some strong non-irritating antiseptic; and the cleansed parts are then isolated by sterile towels, or fresh towels wrung out of a strong solution, the so-called "carbolic or per-chloride towel" is perhaps the best. Only with the gloved hand and after careful separation of the labia is the examination to be made.

During the second stage, the patient must be kept in bed, and with the incidence of the pains, chloroform or ether may be given. When the head "crowns" a choice must be made of the position for delivery. In these spontaneous cases, I prefer the left lateral, as it is in this way easiest single-handed, to watch and protect the perineum. A good technique may be observed though this is not so easy as in the dorsal position. The delivery of the head is most safely effected in the interval between the pains by means of Ritgen's method, the left hand operating between the patient's legs, and favoring the right extension of the head by pressing, first the occiput, and then the nape of the neck forward against the pubic arch. The head delivered, free the neck from any coils of cord, and guard as carefully as the passage of the head, the transit of the shoulders. The left hand placed upon the uterine fundus follows it gently down in the final expulsion of the child.

The anæsthetic is now discontinued, and the woman turned gently upon her back. The child is allowed to imbibe through its newly-established pulmonary circulation the maximum amount of its own placental blood before the cord is cut. The mother's hips are now brought to the edge of the bed, and a registering clamp placed at the vulva upon the dependent cord, while the uterine fundus is simply outlined with the hand, and the conduct of the third stage begins. In such normal cases, this is the stage that requires the most attention, patience and skill. Ample time should be given for the spent uterus to recover, while the fundus is simply guarded in the quiescent hand. At this time, kneading of the uterus should not be employed, as this tends to prevent the formation of the central hæmatoma by which the separation of the placenta is brought about. An armistice of at least thirty minutes should, if necessary, be declared. The fundal hand notes the gradual recovery of the uterus and as the contractions strengthen the patient will again complain of pain. Extrusion of the placenta into the lower uterine segment or vagina frequently occurs spontaneously, and is marked by the elevation of the fundus—the elongation of the uterine axis, and by the escape as measured by the position of the clamp, of three or four inches of the dependent cord. When this occurs the complete expulsion of the placenta may be at once achieved by a voluntary bearing-down effort of the patient herself, or by a modified Crede; the two walls of the uterus being firmly pressed together, and the organ so compressed being pushed down as a piston into the pelvis. Separation of the placenta and its extrusion from the active portion of the uterus is a physiological process, and is usually spontaneous; in most cases it is only its expulsion from the lower uterine segment, or vagina, that requires assistance. While a retained placenta is common enough an adherent placenta is comparatively rare. No traction should be exerted upon the cord, and only as a last resource is the placenta to be sought for by an inserted hand.

Upon its delivery the placenta should be rotated several times in order to weave into a cord the following membranes, so as to secure their complete removal. Kneading of the fundus may now begin, and must be persisted in till the uterine contractions are well maintained. The fundus should be steadily watched by the doctor or the nurse for at least an hour after the delivery of the secundines. The perineum and lower third of the vagina is carefully inspected, and any tear repaired by immediate sutures. In such a normal case, the cervix need not be examined. It may be for the time left to care for itself.

The vulva should be carefully cleansed, and covered by a sterile pad, applied with a T bandage. Ergot need not as a routine be exhibited, and the wearing of an abdominal binder may be left to the inclination of the patient.

The secundines floated in water should be always carefully inspected, special care being taken to ascertain that the maternal surface of the placenta is intact.

Such is, very briefly, our teaching of the conduct of spontaneous parturition. The attempt is always made to instill and enforce the two ideals of cleanliness and a masterful inactivity. It is always declared that each man must master for himself the details of a practical, consistent, workaday technique, make it his very own, always employ it, the staff and the scrip of his obstetrical pilgrimage. So provided, the solution of at least 80 p. c. of his obstetrical problem is assured, the verdict for three-quarters of his work can be pronounced well done.

II. The Problem of the Unengaged Head at the End of the First Stage of Labour.

By this I mean that the cervix is fully dilated, or nearly so; that the membranes are intact or only recently ruptured, while the head is not definitely engaged in the upper pelvic strait. I have chosen this problem as it is one that frequently, and often unexpectedly, meets each one of us, and as upon its proper management so much depends. At first sight too, it is often so simple a complication, so innocent of consequences, and yet if wrongly managed, so frequently it leads to disablement, or even disaster.

The gravity of such a condition is as widely asunder as the poles, according as the patient be gravid for the first time or not. In primiparæ, where the child's head during the later weeks of pregnancy should lie always well engaged within the pelvis, it means in every case no little disproportion of the passenger. In multiparæ, this may or may not be so. In multiparous women, faulty positions of the head, or undue obliquity of the whole foetal axis, as in pendulous belly, may be the single, easily-remedied causal factor. There is, moreover, the guiding voice of the history of the previous labours, and the soft parts below are roomy and well dilated. There is no comparison of the gravity in the two groups of cases, and since, if one can treat the more he can assuredly negotiate the less, I shall deal chiefly with this complication in primiparæ.

I have chosen for discussion here solely these more difficult "order-line cases," if you will, where there is only moderate disproportion between the mother and the child. Such cases are more common, more difficult to recognize and treat, than these where the disproportion is great, the diagnosis in consequence easy, and the choice of interference arbitrary. A simple way to state this problem is to say that here the true conjugate of the mother's pelvis is barely equal to the bi-parietal diameter of the head of the average child; or to express it in figures, the true conjugate measures but 9 cm, while the bi-parietal diameter is 9.1, or 9.2 cm.

In a primipara a conjugata vera of 9 cm. and an average child.

And here a word as to prophylaxis. It is once more the old story that had you been aforetime here, this had not happened. At least it is true that if the essential eight months' visit had been paid, the condition would have been recognized with some four weeks yet to go — four weeks in which to think, to act, or to get assistance. In all primiparæ, I urge again the imperative necessity of such a preliminary visit, though here and now it is too late.

The problem divides itself into two parts: (1) How to ascertain the facts and (2) How to manage the condition. And again, the view only is taken of what we are to teach our average student.

(1) How to ascertain the facts.

The two essentials here are *method* and a *clean technique*. The rectum has, of course, been previously evacuated. Convince yourself first, with a catheter, if necessary, that the urinary bladder is empty, and then, of the presence and vigour of the foetal heart. The vulva, and vulvar slit, are carefully sterilized, and full anaesthesia is induced, for a thorough internal examination must now be made. The diagonal conjugate is first carefully measured, either with the fingers or with a pelvimeter, such as that of Gauss. Eleven cm., a trifle more or less, will be the reading. It matters not at all in such a minor contraction whether the type of the pelvis be a generally-contracted, a justo-minor, or a flat. In both these cases the true conjugate may be left to answer for the pelvis; and this true conjugate is here 9 cm.

There now remains the estimate of the child's head. In such a case this is most readily achieved, I think, by Muller's method of impression. An assistant grasps the brow and occiput of the head from above through the abdominal wall, and presses it firmly downward, and slightly backward into the axis of the pelvis. When this is done, the fingers in the vagina, tracing the margin of the pelvic inlet, upon the head can estimate the degree of disproportion. If single-handed, Munro Kerr's modification may be used, the thumb above the pubis measuring the degree of overlapping. Before the hand is withdrawn, the actual position of the head is verified by complete palpation of the occiput or face, and at the last the size of the pelvic outlet. It need not be re-said that these manœuvres are carried out under a rigid surgical technique.

Corroborative evidence as to the normal size of the child may be obtained by measuring the height of the uterine fundus as 35 cm., and the occipito-frontal diameter of the head as 11.5 cm., by such a method as that of Ellice Macdonald.

The total result of our findings is that the child's head jams with but slight overlapping in the upper strait; and that for delivery, we must depend upon head moulding and compression.

(2) How to manage the condition.

The first injunction and the last is *do not hurry*. While carefully watching the condition of both mother and child, leave the case alone. Statistics here are a great comfort, as they record in 80 per cent of such cases a spontaneous delivery, and as appeared last year in Williams "Questionnaire" the better results of the midwives in such cases was because they did not know enough to interfere.

Some help may be given by posturing the patient. The Walcher position does increase the true conjugate about 1 cm., and the patient should occupy this position at intervals as long as she can stand it. At the same time, during the pains, moderate pressure from above, downward and backward, should be made upon the head. The Scotch midwives kneel these patients before a wooden chair, the chest resting upon the seat, and the hands grasping the back above. In this attitude, the uterine axis falls forward to correspond more nearly with the axis of the pelvic inlet, and engagement of the head is thereby promoted. At least it may be tried.

The first rule is *do not hurry*, and now the second is *do not turn*. Prophylactic version in contracted pelvis is for the expert. In his hands, within certain narrow limits, it possesses certain usefulness. But these limits are too fine, too difficult to estimate for the average practitioner; and any miscalculation means at the very least a murdered child. A pubiotomy or a Cæsarean section are scarcely to be undertaken outside a hospital service.

And so the mother and child are carefully watched, in any ordinary case for at least four hours. If, after this time, the head does not descend, axis traction forceps may be applied. There is here need for great care. Steady moderate traction at intervals, with the woman, if need be, in the Walcher position, will soon decide the issue, it must decide the issue. No great force must be used. If the head does not advance, the delivery of a living child must be abandoned, and our interests now are centered solely upon the mother. With the forceps still applied, the child's head may be perforated between the blades, and so delivered; or a cranioclast may be used. To the general practitioner, the fault is not so great that it has happened once, but grave fault is it, if, with this woman, it happens again.

III. The problem of puerperal infection.

Even as the poor this problem is always with us. In the most careful hands, and with the most conscientious technique, such cases still occur. Mortality and morbidity in the puerperium from this cause alone is still woefully high. As regards mortality, Fromme states that in 1910, in the kingdom of Prussia alone, five thousand women succumbed to puerperal fever. While in Chicago, in the year 1895,

7.3 per cent of women who died between the ages of 20 and 50, died of puerperal infection.

In private practice unfortunately the improvement in the death rate is not so pronounced. Some of the more pessimistic of our teachers in America claim that it is no lower than it was 20 years ago, and a like contention is held in Great Britain. In my opinion, this position is somewhat pessimistic. I am sure that in my own experience of general practitioners and of general practice, the average work is better today than ever before.

The remedy, as I have said before in this paper, lies with, and solely with, a better teaching.

I shall not deal tonight with the bacteriology of the lesion, or the morbid anatomy other than in a very general and practical way. It is useful, I think, for our purpose here to regard these cases solely from the clinical aspect. From this aspect, I divide all cases of puerperal infection into two great groups:

- (1) The toxæmias, and
- (2) The septicæmias.

In (1) the toxæmias, the infection is a localized one, the organisms are saprophytes or facultative saprophytes, and there has been retained within the uterine cavity some dead tissue, placental, membranous, or blood-clot. These organisms remain superficial, and do not penetrate the tissue deeply. There may be considerable constitutional reaction, as evidenced by high fever, a rapid pulse rate, etc., due to the absorption of ptomaines and toxins, and there is always in these cases abundant and foul-smelling lochial discharge. Such cases I call the toxæmias.

In (2) the septicæmias, the organisms are usually the pyogenic cocci, most dreaded of all the streptococcus. They multiply locally, it is true, but penetrate almost at once deeply into the tissue. There are two paths by which they advance, and so they give rise to two clinical pictures.

(a) If the spread is by the lymphatics, the wall of the uterus is rapidly invaded, its parametrium becomes involved, and the spread of the infection is in the parametrium and in the peritoneal cavity. Signs and symptoms of peritonitis show themselves here.* There is meteorism, distension, rigidity, bowel-paresis, and vomiting. The ordinary signs of diffuse-spreading peritonitis. As you know, these cases frequently succumb.

(b) In (b) the spread is by the blood-stream. This is the second path; and if the infection be severe, or the patient's resistance low, acute general septicæmia, with the organism multiplying rapidly in the blood-stream and the internal viscera, gives us the picture of acute

blood-poisoning. There is great prostration, severe toxæmia, high and only slightly remittent temperature, and rapid pulse-rate. And the fatal termination is usually only a matter of days.

If the spread of the infection into the blood-stream be slower, we have produced the thrombo-phlebitic type; the veins of the broad ligament become thrombosed, and this process extends to the iliacs and even to the vena cava. Here occurs the phlegmasia alba dolens, the milk leg, and the pyæmic type of case, which runs a more or less chronic course with occasional chills, and ends sometimes with an embolus into the heart or the lung. The characteristic feature of these cases is the comparatively moderate rise of temperature, but the rapid pulse-rate, and the localized signs of swelling and œdema, the recurrent chills are its most expressive feature.

All cases fall into the above classification. As you readily infer, the distinction between them is all-important, as the treatment of each variety is so separate and distinct.

The Treatment. As usual, the most important factor in the treatment is prophylaxis. We know that the vulva is always a hotbed of organismal growth; and that even in the vagina of the healthy woman organisms, pathogenic, are frequently found. It is safe to say that the vagina of the pregnant woman should not be entered for any purpose whatever during the last weeks of her pregnancy. The danger is that organisms from the vulva be carried upward into the vagina. And that the normal bactericidal action of the vaginal secretion be in this manner impaired. For these reasons, vaginal examinations should be reduced to a minimum. All coitus should be barred, and the daily bath with soap and water, and immaculate clothing should be encouraged.

At the onset of labour, the vulvar hairs should be clipped short with scissors, and the vulva scrubbed with soap and water. Examinations for presentation and position of the child should be external only, and in normal cases the single internal examination should be made after rupture of the membranes.

Such simple procedure, simply carried out, would reduce the cases of puerperal infection in the practice of any man to a minimum.

The faithful and routine examination of the secundines is another important factor. The placenta and the membranes should be always floated upon water and carefully examined, the placenta to see that it is intact, no fragments remain behind; and that the membranes are sufficient, or nearly so, to create the amniotic sac. Such a proceeding means that we know, we do not think, that the uterine cavity is empty. And this fact is such a comfort, especially if trouble arise later on.

It is well in addition to bear in mind the following anatomical facts in respect of the puerperal uterus.

(a) If the uterus is well contracted after delivery all clots will be expelled; it should be globular, firm and hard, and lie midway between the symphysis and umbilicus. As you know, during the next twelve hours, it relaxes and reaches the level of the umbilicus; but then it should progressively and evenly diminish in size, and become lower in the abdomen, till the 10th day, it is just above the symphysis.

The two walls of the uterus are in apposition on the second day.

The internal os should first admit the finger only with difficulty after the fourth day.

And now, within the uterus, at the end of forty-eight hours, the protective zone of granulation tissue has commenced to develop, and at the end of the fifth day, the uterine cavity is protected by this zone against the invasion of organisms, save at the placental site.

These are the conditions found in the normal afebrile puerperium. Any infection whatsoever marks some departure from all, or from some of these findings.

And now, as regards actual treatment of any given case of puerperal infection. If the patient has been delivered by yourself and you are confident that the uterus is empty, save perhaps of blood-clots, and the fever rise on the third day — what are you to do?

Examine the perineum if there are perineal sutures. Examine the breasts for signs of mastitis. Record the level of the fundus uteri in the abdomen. If the lochia be foul, copious, it is wise perhaps to give gently an intra-uterine douche of normal saline; to give it slowly and under low pressure; and this in my opinion should constitute the only local treatment.

If on the other hand, you are not sure that the uterus is empty, and the lochia be foul and copious, you may, after giving the douche, introduce the index finger into the uterine cavity and remove any fragment of decidua or blood-clot found therein. Do not curette the cavity; the protective zone of granulation tissue has on this third day already become formed, and this is the barrier, the sole barrier, against systemic infection.

Prop the patient up in bed to ensure good uterine drainage, and keep her absolutely at rest.

These "smelly cases," to use the old aphorism, are the mild cases, the cases that recover.

In the more severe types of septicæmia, either by the lymphatic or the blood stream, the temperature rises suddenly, the lochia is sweet and may be scanty, or even suddenly suppressed. The uterus is large and sensitive. Involution is suspended. And what is the treatment in such a case?

In my opinion, gentlemen, no local treatment whatever will give you the best results. Prop the patient up in bed, place an ice-bag over

the abdomen, and by means of saline enemata, 10 oz. with an oz. of brandy, given every six hours, forced fluids to drink, or even an intravenous saline, attempt to combat the infection. An admirable paper by Ernest Boyen Young and John T. Williams of Boston, advocates the out-door treatment of such cases; and I heartily endorse here what they recommend. Leave the patient in the open air, and in the sunlight as much as possible. Alcohol is useful in such cases, and you may use what drugs you wish. But such general treatment is the mainstay here. You may try the polyvalent serum if you wish, giving 3 cc. subcutaneously. Autogenous vaccination promised well, but so far, in my hands at least, it is disappointing. Blood injection, with finely divided silver salts, for example collargel or gold salts, produce benefit, I think, only by encouraging leucocytosis.

In a word, in these cases of puerperal septicæmia, the mischief has passed beyond the uterine wall; and local treatment to its internal surface does no good whatever. In these cases maintain drainage, and complete immobility of the pelvic viscera, and of the patient herself. Any movements here merely drive the infection further afield. The battle rages in the lymph and blood-stream, and our efforts are directed toward improving the systemic resistance.

A late infection occurring from the seventh to the tenth day post partum is frequently gonorrhœal in origin, due to a previous gonorrhœal lesion in the tube. Intra-uterine medication is of course contra-indicated here. These cases run usually a somewhat subacute course, and usually, with or without the formation of abscesses, recover.

You can see, gentlemen, that in what I have had to say of the treatment of puerperal fever, I have found small place for the use of the curette.

Medical Notes and Hints.

Salvarsan should always be given a trial in cases of pernicious anæmia. Intramuscular injections are claimed to be more efficacious than the intrevaneous in this affection.

Vaccines are steadily proving of value in acne. Stock vaccines are asserted by some observers to be as efficacious as those that are autogenous in this affection.

Remember the Date of the Meeting, July 2 and 3

MORPHINISM: ITS PROBABLE PATHOLOGY AND RATIONAL TREATMENT.

BY H. B. WEBSTER, CASTINE.

Read before the Hancock Medical Society.

Gentlemen:—In discussing morphinism, I cannot offer you anything new in the way of original research, nor extended clinical experience. But I had the opportunity to observe a fair number of cases in the alcoholic and prison wards of Bellevue Hospital, and to assist Dr. Lambert and Dr. Bishop in carrying out the Towns-Lambert treatment for morphinism on some of their early cases, and recently have used the method on a case in private practice. As the standard text books of medical practice are vague and unsatisfactory in their discussion of this subject, especially in regard to treatment, perhaps the observations and conclusions which I could draw even from my limited experience may be of interest and use to you.

First let me consider the probable pathology of the disease, and remind you of the features which mark it as an organic disease with a far reaching physico-chemical basis and not merely a habit, functional neurosis, or other vagary. The rapid and extreme development of tolerance to the drug is striking. We see the patient taking, almost without effect, a dose which would be fatal to a normal man. Some observers maintain that the greater part of the dose is oxidized and thus rendered inert. Others that it is fixed in the liver and excreted without being allowed to reach a high concentration in the blood. We know also that much is excreted by the stomach mucosa, and by the intestines. But prompt excretion alone cannot explain the immunity toward large amounts of the drug injected hypodermically at a single dose. It is reasonable to assume that the immunity of the morphinic, like the immunity of laboratory animals treated with increasing doses of ricin or other poisons, is due to a specific morphin antibody in the patient's serum which neutralizes or destroys the drug. Next let us consider the withdrawal or deprivation symptoms in relation to this theory of a specific morphin antibody. The first symptom after withdrawal is the subjective craving for the drug; so indefinite as to be described by some patients as merely an instinct, and by others as the foreboding of more severe discomfort. Then a peculiar sensation appears in the back of the throat. Shortly after come lachrymation, sneezing, restlessness, vomiting and spasms of the limbs. Later, delirium develops with feeble and irregular heart action and finally a dangerous or fatal collapse will supervene in cases which have great organic need of the drug. It is typical of chronic morphinism that

the patient does not appear to derive positive satisfaction from the drug, but only the negative satisfaction of relief from deprivation symptoms. Discounting the proverbial untruthfulness of morphinics, still it is significant that this is their almost invariable testimony.

The uniformity of the symptom complex of deprivation, and its fundamental and at times overwhelming character, together with its extreme resistance to symptomatic treatment by other drugs than morphine is proof enough of its organic cause. It is a rank injustice to a morphinic to treat him simply by calling upon the exercise of the patient's will or by forcible deprivation. Assuming the tolerance toward morphin to be due to the formation of a specific morphin antibody, it is rational to believe that the deprivation symptoms may be the effect of the increasing accumulation of unneutralized antibody. The anxiety and restlessness of the morphinic in early deprivation is scarcely affected by the other sedatives and hypnotics; the yawning and spasms of the limbs are even more tenacious. In one case, after giving large doses of bromides and chloral without relief, I etherized the patient to a degree corresponding to deep obstetric anæsthesia, and observed that the yawning and spasms persisted with only slight diminution. In another case, I saw a patient who had been subjected to enforced withdrawal for about thirty hours reduced to a state of collapse, with rapid, feeble pulse which was not improved by the usual cardiac stimulants, but which became strong and steady under liberal doses of morphin. The specific action of morphin in these cases is comparable to the action of diphtheria antitoxin; only in the case of morphin we may assume that the unneutralized antibody is the toxin.

Morphin craving will gradually decline and disappear if the drug is continuously withheld and the patient is not overwhelmed by the strain of withdrawal. This is shown in the method used in some prisons of confining the morphinic in a padded cell until the deprivation symptoms have subsided or collapse has set in, which demanded prompt cessation of this treatment. On subsidence of the craving, the patient's susceptibility returns nearly to normal, though tolerance is more rapidly acquired on resumption of the drug than first beginning its use. Expressed in terms of our theory of morphinism, these facts indicate that presence of morphin stimulates the formation of morphin antibody and that the production of the antibody decreases soon in the absence of this stimulation.

Theoretically then the requisite of safe and humane treatment of morphinism consists in reducing as completely as possible the amount of morphin in the patient and preventing the accumulation of unneutralized antibody to intolerable or dangerous amounts. Both the amount of morphin given and the rapidity of its elimination affect the forma-

tion of antibody. The indications therefore in administering morphin during withdrawal are to give it when necessary to neutralize excess antibody and eliminate it as soon as possible.

The Towns-Lambert treatment though worked out empirically, is a clinical expression of this theory as applied to the average case. When applied to an individual case, it must be varied according to individual peculiarities but the fundamentals of the case are the same. In the practical accomplishment of these aims, advantage is taken of the fact that the administration of belladonna lessens the physiological need for morphin in some way not well understood and lessens the discomfort of severe catharsis; and that hyoscyamus next to morphin itself is the most efficient sedative for morphinics. The Towns "Specific" mixture (15% tincture of belladonna 2 parts, fluid extract of xanthoxylum one part, and fluid extract hyoscyamus 1 part) is given hourly throughout the withdrawal. I do not know the part played by the xanthoxylum but have not tried the experiment of omitting it from the treatment. It is not my intention in this paper to discuss at length the details and variations of the treatment. For these I refer you to the original articles of Lambert and Bishop, whose reprints I have at hand and would be glad to lend you. And I am told in a recent letter from Bishop that his latest article will appear soon in the Journal of the American Medical Association.

The effects of chronic morphinism on the general metabolism, the dry, sallow skin, the sluggish circulation, inefficient assimilation and obstinate constipation are regarded as merely complications. The essential disease is the acquired organic need of morphin to check the deprivation symptoms. To treat this complication which is usually due to irregularity of dosage and over-dosage beyond the organic need, the patient should be put on an allowance given in regular doses at three or four hourly intervals and his actual requirements estimated. During this time, he should be well rested and fed and attention paid to regulation of the bowels and the patient got into training for the coming ordeal. No attempt is made to reduce the intake of morphine, but it will be found that under this routine, the needs of the patient are fully satisfied by an allowance about 25% less than the amount to which he is accustomed.

Then with the patient in the best physical condition attainable under the circumstances, the course of active elimination and withdrawal is begun. A dose of heavy catharsis is given, usually four U. S. P. compound cathartic pills or ten grains of blue mass, followed by a saline. The belladonna mixture is given every hour beginning with a dose of 6 minims and increasing two minims every six hours up to sixteen minims unless symptoms of belladonna poisoning appear.

When the catharsis begins to act, two-thirds of the daily allowance of morphin is given in two doses an hour apart and a third dose may be given an hour later if an appreciable morphin effect is not present. This slightly more than satisfies whatever organic need is present, that is, it more than neutralizes all antibody, but as active elimination is going on this morphin has the minimum effect in stimulating the further formation of antibody. The routine four hourly dosage of morphin is stopped. Ten hours after this massive dose of morphin, a second round of catharsis is given, and four or five hours later when this has begun to act, a single dose of morphin is given which is half the total quantity given after the first catharsis. Clinical experience shows that this is usually enough to relieve the organic need, that is to neutralize the relatively smaller amount of antibody that has accumulated since the last dose. Rapid elimination of both drug and antibody occurs as before, and ten hours after the second massive dose of morphine, a third round of heavy catharsis is given. When this has begun to act it is found that one-half the previous dose of morphin is sufficient to allay the craving, as the accumulation of unneutralized antibody is very slight. Ten hours after this, a fourth dose of catharsis is given, this time usually a mercurial followed by a full dose of castor oil which sweeps out all the remnants of catharsis and leaves the patient without the tenesmus which would otherwise ensue. Whatever unneutralized antibody may have accumulated since the last dose of morphin is small so that in most cases none is needed with this round of catharsis. But should deprivation symptoms arise severe enough to require morphin, an even smaller dose may be given but a fifth round of catharsis will be necessary ten hours later. After the fourth round of catharsis, the stools are usually nearly pure mucus and bile. Formerly considerable emphasis was laid on the necessity of obtaining the "critical bile stool" but later cases showed success even when this did not appear. Most cases at this stage show only slight subjective craving, but very seldom the yawning, vomiting and spasms so distressing in simple deprivation whether after slow reduction of dosage or abrupt withdrawal. The patient is exhausted but convalescence is usually rapid. A remarkable feature of the treatment is the change in complexion from the muddy, sallow, dry skin of the morphinic to a healthily moist, pink and white complexion almost like that of a healthy child. The belladonna mixture may be omitted at once after the last catharsis or may be gradually reduced during the next 24 hours if craving still persists.

The appetite returns after cessation of catharsis and food usually relieves whatever occasional craving arises in the next few days. The patient gains rapidly in strength and flesh.

Though simple in theory and in accord with the probable pathology of the disease, the actual administration of the Towns-Lambert treatment must be varied to fit the case, and should not be attempted unless the patient can be under constant supervision of a good nurse night and day, and can be visited several times a day by his physician. During the critical periods of treatment the patient may need constant attendance by the physician unless the nurse has had previous experience with cases of this kind, complications unless met early will wreck the treatment and prove disastrous to the patient. Vomiting may be from failure to overcome the organic need of morphin or from irritation of other medication. Delirium may be due to overdose of belladonna, exhaustion, or need of morphin. Collapse from cardiac fatigue and depletion may be prevented by routine observation of blood pressure and heart signs; a fall of pressure with dilated heart indicating digitalin and strychnine and fall of pressure without dilation or irregularity indicating replacement of fluids by ingestion or in rare cases by hypodermoclysis.

As the purpose of this paper is primarily to discuss the pathology of morphin addiction and principles of treatment rather than details of administration, I shall refer you to the above mentioned reports for guidance in cases you might wish to treat.

(See following pages for Case Reports)

A. M. A. Minneapolis Session.

The 64th Annual Session of the American Medical Association will be held at Minneapolis.

There are 15 scientific sections. The general meeting, which constitutes the opening exercises of the scientific program of the association will be held at 10.30, A. M., Tuesday, June 17th. The various sections will meet Tuesday at 2 P. M. and subsequently according to their program on Wednesday and Thursday, June 18th and 19th, and in some cases on Friday morning, June 20th.

The registration department will be open from 8.30 A. M. until 5.30 P. M. on Monday, Tuesday, Wednesday, Thursday, June 16, 17, 18 and 19, and from 9 to 10 A. M. on Friday, June 20th.

***Remember the Date of the Meeting,
July 2 and 3***

CHART I

Type Case — Patient free from organic disease other than morphinism. Preliminary treatment shows that 6 gr. of morphin per day, given in doses of gr. 1, q 4 h, satisfies the organic need of the patient.

Hour	Catharsis	Bell. Mixt.	Other Med.	Dej.	Morphin	Remarks
1	4 cc pills	m 6			gr. 1	Blood pressure 120
2		m 6				Light meal of liquids and soft solids
3	Mag. Sulph 1 oz.	m 6				
4		m 6		II	gr. 2	
5		m 6		III	gr. 2	Pt. drowsy. Gripping moderate
6		m 6		II		cereal c cream, 2 boiled eggs
7		m 8		I		Sleeping
8		m 8				Sleeping
9		m 8				Sleeping
10		m 8		I		Blood pressure 120
11		m 8				
12		m 8				Gruel oz. VIII
13		m 10				
14		m 10				Slight craving
15	Blue Mass gr. V	m 10				
16	Blue Mass gr. V	m 10				Yawning, slight twitching of limbs
17		m 10				
18	Mag. Cit. dr. ss	m 10				
19		m 12				
20		m 12		II	gr. 2	Satisfied
21		m 12		III		
22		m 12		I		Toast, oatmeal and milk oz. VIII
23		m 12				Blood pressure 115
24		m 12		I		Sleeping
25		m 14				
26		m 14				
27		m 14				Soup oz. VIII, bread and butter
28		m 14				
29		m 14				Blood pressure 115
30	Blue Mass gr. V	m 14				Face flushed, somewhat restless, indicates omit belladonna
31	Blue Mass gr. V	m 14	Digitalin gr. 1-100 Hyocine gr. 1-100			Talkative, slightly confused
32						Blood pressure 110. Vomited
33	Mag. Cit. dr. ss					Quieting
34						Drowsy, quiet
35			Digitalin gr. 1-100	I	gr. 1	
36				III		
37				II		
38				I		Blood pressure 110
39		m 6	Digitalin gr. 1-100			
40		m 6				
41		m 6				
42		m 6		III		
43		m 6	Digitalin gr. 1-100	III		Tenesmus relieved by high enema of normal salt sol.
44		m 6				
45		m 8		I		
46		m 8				
47	4 cc pills	m 8	Digitalin gr. 1-100			Blood pressure 100
48	Calomel gr. ½	m 8				Vomiting. Slight morphin craving
49	Calomel gr. ½	m 8				Restless, weak, despondent
50	Calomel gr. ½	m 8	Trional gr. XV			Some yawning and sneezing
51		m 10	Digitalin gr. 1-100			
52	Castor Oil ozs. II	m 10		I		
53		m 10		II		Stools consistency of thick soap, mostly bile and mucus
54		m 10		II		
55		m 10	Digitalin gr. 1-100	I		Blood pressure 105
56		m 10				Slight flushing of face and excitement
57						
58						
59		m 6	Digitalin gr. 1-100	I		Slight craving previous to copious stool. Symptoms subsided. Asleep
60		m 6	Trional gr. XV			
61		m 6				
62						

CHART II

Patient, G. H., age 50. Duration of habit 1½ yrs. Begun on account of neuralgias subsequent to administration of salvarsan for syphilis of 6 mos. duration. Daily allowance of morphin 2 grs. Hyoscina gr. 1-100, usually taken at 8 p.m. and 12 m., and often Veronal gr. 12, because morphin did not control insomnia.

Catharsis	Bell. Mixt.	Other Med.	Dej.	Morphin	Remarks
4 cc pills				gr. ¼	Blood pressure 120
Mag. Cit. dr. ss	m 4				
	m 4				
	m 4				
4 cc pills	m 4			gr. 1	Some morphin craving
	m 4				Vomited once
	m 6		III		
	m 6		II		
	m 6		I	gr. ½	Restless, considerable craving
	m 6		I		Blood pressure 120
	m 6				
	m 8		I		
	m 8				
	m 8				
4 Cath. Active Pills	m 8				
	m 8				
Mag. Cit. dr. ss	m 8				
	m 8				
	m 8		III	gr. ½	Blood pressure 110
	m 10		III		
	m 10	Digitalin gr. 1-100	I		Blood pressure 100
	m 10		I		
	m 10		I		
	m 10	Digitalin gr. 1-100			
	m 10				
4 cc pills	m 10				
	m 10	Digitalin gr. 1-100			Blood pressure 85
Mag. Cit. dr. ss	m 8	Digitalin gr. 1-100			
	m 8	Strych. gr. 1-50			
	m 8		II	gr. ¼	
	m 8		II		
	m 8		I		
	m 8	Digitalin gr. 1-100			
	m 12	Strych. gr. 1-50			
Calomel gr. ½	m 12		I		Vomiting and restlessness
Calomel gr. ½	m 12				Blood pressure 100
Calomel gr. ½	m 12				Still rather restless
Calomel gr. ½	m 12		I		Somewhat excited
4 Veg. Cathartic		Hyoscine gr. 1-100			Face flushed, delirious
		Digitalin gr. 1-100			Extreme restlessness
		Chloral gr. X	I		Spasms of limbs
		Sr. Br. gr. XX			
		Chloral gr. X			Yawning. Hot foot baths
		Sr. Br. gr. XX			
		Camphor in oil			
		gr. II			
		C-E Sequence to light anæsthesia			Belladonna symptoms subsiding, morphin deprivation chief feature of picture
		Chlor. gr. X			
		Sr. Br. gr. XX	II		
		Digitalin gr. 1-100			Considerably quieter after copious stools
					Asleep in naps. Twitching of legs and yawning still present fairly often but less violent. Stool bile and mucus
		Digitalin gr. 1-100	I		
		Chloral gr. X			
		Sr. Br. gr. XX			

Symptoms continued to improve, slight craving at times during next 4 days, which was relieved by food. Insomnia for a week, resisting veronal, chloral and bromides. Rapid return of appetite. Health and strength much better.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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***Remember the Date of the Meeting,
July 2 and 3***

Editorial Comment.

State Journal.

The Journal of the Maine Medical Association closes its third year of existence with this issue. It has carried on the work previously done in the old transactions and published more or less complete reports of the county meetings, together with some few of the papers read at the various meetings. Under Personal News and Notes, we have endeavored to get at the change of location made by different members of the Association as well as personal notes which were of interest to all members.

Under the head of Medico-Legal, an effort was made this year to obtain true copies of quarantine and State laws relative to health matters together with the various acts submitted at the last session of our legislature. To those who have the Journals bound these laws will be useful for reference as any changes will be noted in the future issues of the Journal.

The present issue contains a complete index of each of the three volumes published so that the volumes can be readily bound and placed in one's library.

Under the heading of Reviews of Current Literature, there has appeared each issue reviews made by members of the Journal club of important articles appearing in the various Journals.

Under Necrology, Dr. Spalding has endeavored to place upon record such data as he could obtain of the lives of each deceased member. This work is carried on with the idea of getting a true record of each member. This year, he has sent out return postal cards to every active member in the State Society with a request that he fill in certain data which would facilitate his work.

In the editorial column, efforts have been made to touch upon matters of interest to all readers of the Journal.

Perhaps a few men realize the great amount of work required to carry on a good journal of this kind and how important it is to have the co-operation of all members. The Editorial Staff have labored to secure the confidence of the profession and endeavored to place before the members all matters which in their mind are important and at the same time eliminate unnecessary material. If the county societies would instruct their secretaries to send in complete reports of the meeting or true copies of the transactions of the meetings, leaving it for the editorial staff to publish whatever they deemed wise, it would make the Journal of more value as the official organ of the county societies.

State Meeting.

Various reminders are scattered through this Journal, bringing to your attention the changed date of the annual meeting of the Maine Medical Association. The postponing of the date of the meeting to July 2nd and 3rd was done by a vote of the councillors, and was made necessary by the conflict of the previously assigned date with other events which were of interest to the profession. The change was therefore made in the hope of fixing a date that would bring to the meeting a larger number of the men from the State.

With this change of date, the committee is sure that it can offer the visiting doctors and their wives a much more entertaining trip to Portland than at the old date. And this annual meeting is arranged to be, for the wife as well as the doctor, an outing away from the cares of practice for the doctor, and an opportunity for amusement as well as shopping for the wife. A committee of ladies has been given charge of entertaining the visitors during the sessions of the convention, and what we consider a pleasant program has already been provided for. Wednesday morning when registering, each doctor will be given tickets for his wife for an afternoon performance at one of the local theatres where a block of seats has been reserved; will be asked to obtain tickets for the banquet on that evening where bright speakers will entertain us all; will be told where a party will

congregate the next morning for the start of an automobile ride about the city; and will be given tickets for a two-hour sail down the ever-beautiful Casco Bay on specially chartered steamer the next afternoon. A recital by the Municipal Organist on the new Herman Kotzschmar organ is also promised, the time to be arranged later.

As the meetings of the convention end with a clam-bake Thursday night, the members will be able to rejoin their families at an early hour in the evening, and enjoy the thrills of an "evening before" a sane Fourth of July.

Portland is even now well along in its plans for a celebration of the Fourth that will be well worth witnessing, being novel in its conception, and promised to be magnificent in its fulfillment. Plan to stay over this holiday. Portland wants to entertain the whole State.

We are asked to put in a special word about the annual dinner. This will be held this year at the Congress Square Hotel, on Wednesday evening. As an innovation in this society, the ladies are to be urged to attend. Many doctors to whom this idea has been suggested are very enthusiastic about it. Speeches will not be on medical topics. It is not a dressy affair. There will be lively music all the time. Come with your wife, and let us meet socially those women who are behind us in our every undertaking, and yet who have not before been admitted to the pleasures of our annual convention.

Plan to come. Begin now. If you wish any further information on the annual meeting, rooms reserved at a hotel, or the like, write Dr. H. J. Everett, 727 Congress St.

Another "Cataract Absorbent" Exploded.

Just as our papers are filled with "CURES" for Tuberculosis, so those of Germany are exploited with notices of wonderful cures for all varieties of diseases. One of the latest publicities was the asserted discovery of a New Method of Absorbing Cataracts, so that operations would no longer be needed. Thereupon, a medical friend wrote to the alleged discoverer (a noted Oculist) and had from him a reply to this effect:

I am sorry for the rumor that I can absorb cataracts so that no operations are needed to make the blind see. The truth of the matter is, that I have for years experimented with all sorts of remedies to be dropped into the eyes of cataractous patients, but I did not obtain any good results until I devised a cataphoresis electrode. The results, however, that I have so far obtained consisted in nothing more than in apparently clearing up incipient opacities in the lens. Such changes have been so exceedingly slow and wearisome, that I am

quite sure that few people will ever have the patience to try the method. I am, however, preparing a paper for publication, and when it appears you can understand exactly how much, or rather, how little, I have so far accomplished.

The example of this single learned man disclaiming unearned fame is worthy of imitation. Assertions can be made in a day, but beneficial results demand a year and a day for proof.

Medical Psychiatry on the Typewriting Machine.

To those who use a type writing machine:

Did you ever think that the placing of the figure o and the letter o on the same key of your machine would save you and a million other people that fraction of time and that atom of mental wear and tear on your brain which is needed to distinguish between the two keys, one with a g and an o, the other with a p and o? Although this is an axiom, a self evident truth and something not to be denied, it has so far proved impossible to induce a single type writing machine manufacturer to move out of the rut of the Universal Key Board. What is needed is a key with one o on it for letter or figure; whilst the p key shall be convertible into g in case a figure is needed. This is a trifle, but the brain wear and tear by the present keys is something enormous.

The Motor Car Crematory.

The Motor Car Crematory is most favorably mentioned in a recent number of the "Militar Wochenblatt," the idea being that after battles many hundreds of bodies remain insufficiently covered with earth, and that they thus remain a danger to people living near at hand. Dr. Blau, an enthusiast in cremation, proposed to employ ambulatory cremation furnaces to follow fighting armies and to burn the dead at once, instead of making any attempt at old fashioned burial. Napoleon, he urges, incinerated bodies on his retreat from Moscow and the plan was carried out on a small scale after the Russo-Japanese war. It is now carried out on a larger scale during present day fighting in Bulgaria.

Medical Examination of Motor Car Drivers.

Physical examination of motor car drivers has been advocated by many owners and is in force in some parts of the world. In others it is ignored as useless. It would seem positively sure that no person would offer his services to drive a motor car unless he understood how to do it, because in driving a car without proper knowledge he would be endangering his own life and limb. Many accidents, also,

are due to mere nervousness to approaching danger, and that, even with persons who understand thoroughly how to drive a car.

Leaving aside as of doubtful value the examination of capacity for driving a car, and possible nervous excitement which no examination would ever reveal, there can be no reasonable doubt that all motor car drivers should be tested for hearing and sight. Perfect hearing is demanded in order to know that the machinery is running properly. It is also demanded to perceive dangers from cars running in from behind. The hearing should be perfect in one ear, and at least two-thirds of normal in the other ear.

The sight ought to be normal in one eye, and at least one-half of normal in the other. If lenses are used habitually, they should be fastened to the face with bows behind the ears so that by no human possibility could they be detached by a violent gust of wind. Those who wear lenses habitually, should have in their tool box a duplicate pair in case of emergencies and accidents. Furthermore, the field of vision should be examined with the greatest care, because upon it depends the possibility of danger from objects approaching from in front or from behind or from the sides on narrow roads. With a good field of vision the nearness to the gutter can be estimated properly. One-eyed persons should be ineligible for driving cars for hire.

Expert examination along these lines has been tried in Germany and found to be of great value to private owners of motor cars. A small fee to an expert oculist would be well worth its amount to the man who wished for employment in driving private cars, whilst owners of cars who did not personally drive their cars would feel satisfactory safety with a man whose eyesight and hearing they knew to be perfect.

Medical examination outside of tests for sight and hearing have for some time been carried on in England but have not so far proved of any special value to owners or to drivers.

Swimming Pool Conjunctivitis.

Swimming pool conjunctivitis is a newly discovered disease of the conjunctiva mentioned first by Dr. Paderstein of Berlin, who has observed fourteen cases of the sort in men, all of whom belonged to swimming clubs and were in the habit, for many months in the year, of swimming for prolonged periods in the public club tank. The affections were unilateral in twelve patients, bilateral in the others. It resembles true trachoma, somewhat, is slow in its progress to recovery, and often leaves a permanent, though slight ptosis. It is contagious and can be inoculated upon monkeys.

If this discovery shall be confirmed by other observers, it is plain that proper disinfection of the water in public swimming tanks will not only be in order, but better still, a preventive may be found in emptying the tank daily, instead of once a week as is the custom hereabouts. . . . Where disinfectants are used, the best is said to be one pound of chlorite of lime in 50,000 (fifty thousand) gallons of water, every twenty-four hours. Smaller amounts of lime will, of course, be utilizable in tanks of smaller capacity than the one just mentioned.

Anti-Typhoid Vaccination of Trained Nurses.

Anti-typhoid vaccination of trained nurses, as advocated by Dr. Spooner, in the recent number of the Journal of the American Medical Association, seems on its face to be of undeniable benefit as a prophylaxis, because trained nurses are eight times as much exposed to the disease as other individuals. The morbidity, in unvaccinated nurses, was nine times greater than in those properly and often vaccinated with small amounts of low virulence. The blood pictures indicate certain protection against typhoid for at least two and a half years. The use of this means of protection has shown it to be safe, in at least two epidemics, and very efficient always.

Nothing New Under the Sun. Not Even in the Hideous Goggles of To-day.

Two hundred and four years ago today, Jean Baptists Chardin (Call him SHARDAN, with accent on the last syllable) a great French artist was born, and in 1779, he ceased from his labors. Those who visit Paris should make a pilgrimage to the Louvre and there on its walls they will see a portrait of Chardin painted by himself, and wearing the same horrid, unbecoming, stylish and fashionable goggles that are perched upon the noses of people of today. Let us be thankful that this is a fashion, because being fashionable it will pass away and be forgotten for another double century only then again to be paraded as "the very latest fashion."

So when you want to be in the fashion with your lenses, don't fail to demand "goggles a la Chardin."

Remember the Date of the Meeting, July 2 and 3

Necrology.

ERASTUS LOZIER WILSON.

Dr. Wilson, one of our associates, was born in Waldo, Maine, December 2, 1863, the son of John and Louisa Wilson of that town, received an ordinary common school education and obtained his degree at the College of Physicians and Surgeons in Baltimore in 1889. He acted for two years thereafter as Assistant Superintendent to the Bridgewater, Massachusetts Insane Hospital, and was for the five years following that period Assistant Superintendent of the State Insane Institution at Howard, Rhode Island. During this period of his life, he became a member of the Massachusetts, and of the Rhode Island Medical Societies.

He then decided to labor for himself and consequently settled in Lisbon Falls, Maine, in 1897, and practiced there up to the last day but one of his life.

Soon after settling in this town, he married Miss Rosie Elmira Monroe, daughter of Albert and Elmira Monroe of Thorndike, who brought him two children. One of these died early from rheumatic-cardiac affections and the other from infantile paralysis. Dr. Wilson at one time added the business of a druggist to his medical practice, but after a thorough trial abandoned it as too laborious and unremunerative.

The manner of his departure from his busy life was this. He was attending a lying-in case far from home when he suddenly became paralyzed and suffered excruciating pain in his head. He was just able to send a message to his wife for help, when he became unconscious and was at last brought home early the next day but never regained consciousness in the least. He died Monday, February 22, 1909. Even at this late day, these few words are to recall the memory of one who by too prolonged and too steady labor for humanity, was carried along before his time.

J. A. S.

FLORIMAN JAMES TAYLOR.

This valuable member of our Association was born in Jay, Maine, December 15, 1854, and died in Pittsfield, May 24, 1909. He was educated in the common schools of Jay, studied at Wilton Academy and then at the Farmington Normal School. Directly after his graduation he taught boys in the famous Little Blue School at Farmington,

and in the year following, he went West and was a teacher in Glenwood, Illinois. He then decided to return to Maine, where he taught efficiently in several rural schools, and completed at intervals a college preparatory course at the Nichols Latin School in Lewiston.

During these years devoted to teaching, his mind gradually veered toward the study of medicine, and in 1879, he turned steadily to that profession, and at last obtained his degree of M. D. at the Rush Medical College in Chicago in 1881.

He immediately settled in Pittsfield, married Miss Nellie Vaughan of Chesterville, occupied at first an office in the Lancey House and after years of good success built a fine residence with an office on Main street, near the public library.

As time went on, he prospered, his practice extended, he took an active part in town affairs, interested himself in the public schools, was long on the pension examining board, and was highly esteemed as a physician and citizen. He often attended our meetings, and showed constant interest in the advance of the profession. His valuable paper on "The Therapeutics of Whooping Cough," read before our society in 1899 attracted much attention at the time of reading, and called forth a favorable and animated discussion.

J. A. S.

TRUEMAN MERRILL GRIFFIN.

After a long illness which confined him to his house and bed from the previous autumn, Dr. Griffin, an active member of the Association passed away on Monday, April 8, 1911.

He was born in Stockton, Maine, June 30, 1853, the son of Isaac Griffin and Deliah Staples his wife, was one of a family of twelve children, and after ordinary education at home was graduated at the Maine Central Institute at Pittsfield. He next studied medicine with the late Dr. Manson, one of the ablest physicians in that vicinity, continued his studies one year at the Medical School of Maine, but obtained his medical degree at the Medical School of the University of New York in 1883. He soon found a place for practice in Harmony, Maine, where he remained two years, and in 1885, removed to Pittsfield, where he soon built up an extensive medical practice, becoming well recognized throughout Maine as a capable man in surgery and diagnosis.

Dr. Griffin was married, June 20, 1883, to Miss Lottie Gifford of Plymouth, Maine, and was survived by her and by two children. Dr. Griffin often took part in our meetings, was active in connection with

the American Medical Association, a prominent Mason and a member of many beneficent societies. He was a man greatly devoted to his friends, and always retained an affectionate remembrance of the town of his birth.

J. A. S.

GEORGE ZOETH HIGGINS.

Wonder may be expressed that your necrologist should go so far back into the history of this Association as to write a notice of the life of a member so long since dead and maybe forgotten, but he feels that one incident in that life is worth recording once and for all in the pages of the Journal of the Society to which he belonged. Know then, that this brave man, the son of Hon. Ebenezer and Ruth Smith Higgins was born in Bucksport, Maine, December 29, 1832. His father was very prominent in Anti-Slavery days, and was very intimate with the celebrated William Pitt Fessenden, of whom the State is proud.

George, the son, was educated at Phillips-Andover Academy, where he was graduated in 1855, and then studied medicine earnestly; first at the Medical School of Albany, New York, and then at the Medical School of Maine, where he obtained his degree in 1858. He then practiced in Lubec, Maine, and later on in the adjoining town of Pembroke. During the Civil War, he acted as surgeon to the 15th Maine Regiment of Infantry, and after a battle whilst attending upon the wounded, the chance was offered to him to be set free to join his regiment, or to remain with his captured comrades, and attend them during their journey and whilst remaining in a Confederate prison. His heroism and devotion to his comrades decided him to partake his chances with them and for several months, he suffered the hardships of imprisonment. He finally obtained an honorable release and resumed his practice in Lubec, where he carried on an excellent business until 1878.

Ever after his return from imprisonment, Dr. Higgins had suffered much from symptoms of malarial poisoning, and unable to endure them longer, he left Lubec and settled in Strong, Maine, far from the salt water and hoped for beneficial results. He had a fine practice and maintained it for the remainder of his life, and finally died in December, 1898, from cirrhosis of the liver. He is survived to this day by a widow, who was born, Kate Ford Lamson of Lubec, and by a daughter, Dr. Lelia Higgins, an active member of the Association to which we belong.

J. A. S.

Maine Medical Association

Program of the Portland Session, at the City Hall,

Wednesday and Thursday, July 2 and 3, 1913.

Clinics will be arranged for.

Morning Session, 11.00

The Eye as Affected by Constitutional Diseases. James A. Spalding, Portland

Abstract. Dr. Spalding's paper deals briefly with the eye as a part of the human body, and as a participator in its diseases. So too within the eye we often observe the first symptoms of bodily diseases. As a result of such connection we find frequent need of lenses to relieve symptoms of defective vision. And the specialist who looks at diseases of the eye without knowledge of their dependence on constitutional disorders will often find himself at loss for proper treatment. In these days when legislation is throwing an enormous mass of eye diseases into the hands of uneducated men, because they can advertise publicly, it is the duty of physicians to recall to mind the innumerable instances in which diseases and irritative conditions of the body manifest themselves in the eye, and really belong to medical practice. Various recent cases in private practice are detailed, briefly in the paper, with a view of obtaining discussion and suggestions for treatment from the members of the Association.

Discussion opened by Dr. J. F. Hill, Waterville and Dr. S. J. Beach, Augusta.

Heroin Addiction.

Paul K. Sellew, Brookline, Mass.

Abstract. Resume of the literature on heroinism. Five cases treated by himself by the Towns-Lambert Method. The addiction to morphine and synthetic derivative, such as, heroin and dionin, is on the increase. The rural districts and the most congested sections of the cities are the hot-beds for narcotism—from diametrically different reasons. Scarcely any attention has been paid to the risks encountered by the frequent use of heroin and dionin. The former is commonly recommended for respiratory disturbances without reckoning the possible consequences as few references to these dangers can be found. The prevalence of, and the increase in, the habitual use of heroin is not generally known. The cases cited, self-administered the drug per os per rectum, subcutaneously and by snuffing into the nose, the latter being perhaps the most common route chosen by real drug fiends. Many have acquired this addiction in an effort to cure themselves of morphinism, resulting in a much worse condition. Heroin is certainly as harmful as morphine and its toxic effects are nearly three times greater. It is a potent opiate. It has all the disadvantages of morphine and carries with it more dangers. The heroin habit is more grave and becomes even more firmly fixed than the morphine habit. Heroinism is second only to cocaineism. A physical and intellectual debility much more pronounced is reached in less time under heroin than under morphine. The deprivation from heroin is more difficult and more dangerous than is the withdrawal of morphine. The convalescence from heroinism is much slower. Another

subtle drug is dionin which is practically analogous with heroin as regards its habit forming effects. Whenever a physician considers it necessary to prescribe a potent sedative he should think of morphine rather than heroin.

Greater forethought in prescribing and more stringent laws to control the dispensing of habit forming drugs are necessary.

The Alcoholic Psychoses.

F. C. Tyson, Bangor

Abstract. During the past five years, there have been admitted to the Bangor State Hospital, exclusive of transfers and other admission, 800 patients, among which were 62 cases of alcoholic insanity.

Alcohol is an important etiological factor in many psychoses other than the typical alcoholic group. This group should be closely restricted to those cases in which alcohol in the form of chronic drinking, produced a characteristic symptomatic picture. Acute alcoholic hallucinosis, a well defined type, sudden in onset, of short duration, with a good prognosis, is the most frequent form. Korsakow's, or polyneuritic psychosis, is the most frequent form with us, has an unfavorable prognosis, a complete recovery being rare, the usual result being mental and physical deterioration. Other clinical forms are delirious and confused states, paranoid states, and chronic alcoholic hallucinosis. Analysis and presentation of typical cases.

Artificial Pneumothorax.*

F. J. Welch, Portland

Afternoon Session, 2.00

Latest Laboratory Tests which are of Value in Diagnosis.†

F. N. Whittier, Brunswick

Abstract.

Prophylaxis in the Army.

William H. Wilson, Ft. McKinley

Abstract. Preventative measures adopted in the Army against various diseases especially typhoid fever and venereal diseases.

Measures adopted against venereal diseases.

Regular and systematic physical inspections of the men.

Restriction of those found diseases.

Administration of the following preventative after return and exposure: Washing of parts, use of Argyrol or protargol and an ointment of calomel.

Issue and use of the "K" packet.

Instruction by lectures, talks, etc.

Comparison of our Army with others and civilians.

Statistics from the Surgeon General's report.

Alcohol as a factor in causing these diseases.

Measures adopted against typhoid fever.

Especial reference to vaccination against this disease. Brief description of vaccine and method of giving it. Use of it now compulsory in the Army and Navy. Several instances where

its use has reduced typhoid rate and mortality. Recommending its use among the militia, school children and those persons travelling and visiting Summer resorts.

Discussion opened by Dr. B. F. Bradbury, Norway, and Dr. Alfred Mitchell, Jr., of Portland.

Etiology of Goitre.

F. E. Leslie, Andover

Abstract. (a) Increased interest in abnormalities of the thyroid gland during the last three years. (b) Goitre is becoming more common. (c) Physiology of the thyroid gland. (d) Iodin a necessary normal constituent of the gland. (e) Theories of the cause of goitre: 1. A nutritional disturbance; 2. Of central nervous origin; 3. Drinking water; 4. Geological formation; 5. Bacterial origin. (f) Investigations of goitrous sections. (g) Experiments with drinking water. (h) Brief mention of treatment.

Annual Oration, "Typhoid Fever."

David L. Edsall, Boston

RECEPTION ANNUAL BANQUET

July 3, 1913.

Morning Session, 11.00

Treatment of Compound Fracture (Symposium)

Conservative Treatment.

Hiram Hunt, Greenville

Abstract. Importance of subject to general practitioners. Meaning of terms conservative and radical. Different views of authorities as to rule of treatment. Desirability of having a generally accepted rule.

Importance of proper early treatment. Dangers of too energetic initial treatment in general practice, as a rule. Cleansing with iodine or alcohol a sterile dressing, with light pressure splints and suspension are sufficient for early treatment.

Radical Treatment.

W. C. Peters, Bangor

The Treatment of Fractures with Lane Plates.

A. D. Sawyer, Fort Fairfield

Radiography.

F. W. Lamb, Portland

Abstract. The Use of the X-Ray in the Diagnosis and Treatment of Fractures.

1. Difficulty of diagnosing fractures by the so-called cardinal signs. 2. Advantages of the X-Ray over manual examination. 3. Types of Fractures where diagnosis may be made only by X-Ray. 4. Routine use of the X-Ray in fractures.

Afternoon Session, 2.00

Ectopic Gestation.

W. Bean Moulton, Portland

Knee Joint Surgery with Lantern Slide Illustrations.

W. R. MacAusland, Boston

NOTICE

The Entertainment Committee of Cumberland County Medical Society are making special effort to provide entertainment for the visiting doctors, wives and families during the two days' stay.

A theatre party for the ladies will be provided for Wednesday afternoon, while on Wednesday evening they will be invited to attend the annual banquet.

On the morning of Thursday, an automobile ride will be arranged for, while in the afternoon arrangements are in progress with the view of giving them a sail down the bay, previous to the clam bake.

Every effort will be made to give the visiting ladies an exceptionally good time. On the other hand, if the attendance is not sufficiently large to warrant continuing this plan, it will not be tried again. Better make this a family vacation and we will promise you a good time.

Address all communications relative to entertainment, hotel accommodations, etc., to Dr. H. J. Everett, 727 Congress St., Portland, Me.

***Artificial Pneumothorax.**—Artificial pneumothorax is an operation which consists in filling the affected side of a tuberculous chest with a gas, preferably nitrogen. In 1895, Forlanini in Italy reported the first clinical cure. In 1898 J. B. Murphy in the American Medical Association surgical oration independently contributed the results of his original observations. The methods of each were different in regard to the introduction of the gas. For some time the work in the United States was abandoned from no sufficient cause until in 1911 when Robinson and Floyd of Boston reported their series of cases. Since then there has been a general revival of interest in the procedure. Discussion of Artificial Pneumothorax: treatment by the method of Forlanini; theories of its action; pathology; indications and contra-indications for treatment; description of apparatus; technic and preparation of patient; operative casualties; changes in clinical findings; preliminary report of cases; conclusions; demonstration of cases. Discussion opened by Drs. Burrage and Gehring.

†**Latest Laboratory Tests.**—General tendency is to recognize the greater importance of bacteriological and biological tests as compared with chemical tests. Some chemical tests, however, maintain their positions of importance. 1. Food; a. Tests for colon bacillus in water; b. Tests for infection in milk. 2. Urine; a. Tests for albumin; b. Tests for sugar. 3. Sputum; Digestion test for tubercle bacilli. 4. Blood; a. Bacteriologic tests; b. Complement fixation tests; Wassermann test for syphilis; Naguchi modification of Wassermann test; Complement fixation test for gonorrhea; Complement fixation test for glanders. 5. Serous fluids; Sero-diagnosis. Discussed by Dr. Herbert E. Thompson, Bangor and Dr. Herbert W. Hall, Augusta.

JUST AS GOOD.

A patient visited a great and good doctor on his dying bed and seeing his faithful medical adviser passing along without a chance for recovery, he began to weep and lament, and finally sobbed out:

"Oh, doctor, who shall I send for when you are dead and gone?"

"Oh, get the nearest one. He will be just as good as I."

Personal News and Notes.

During the past month, Dr. E. G. Abbott of Portland was elected to membership in the American Orthopedic Association, in recognition of his epoch making discovery in the treatment of scoliosis. Dr. Abbott's work had previously been accepted by the French and German Orthopedic Societies.

Dr. J. E. Walker of Thomaston has returned from a trip to Boston, New York and Philadelphia.

Dr. A. W. Foss of Rockland, is visiting in the southern part of the State.

Dr. W. E. Kershner, formerly of the Army Medical Service, has opened an office at Bath, where he will confine his practice to the eye, ear, nose and throat.

Dr. A. P. Reid of Naples has returned after serving as resident physician at the Altemonte, and resumes his practice at Naples.

Dr. Percy E. Gilbert of Linneus has moved to Ashland.

Dr. F. A. Larrabee is now practicing in Warren.

Dr. E. B. Skolfield, formerly of Lisbon Falls, is now located at East Corinth.

Dr. A. J. Fuller, who also has practiced for a number of years in Vermont, is now located on Swan Island.

Dr. H. B. Webster has opened an office at Castine.

Dr. H. L. Williams has removed to Castine, where he confines his practice to the eye, ear, nose and throat.

Dr. A. E. Schriver has removed from Mars Hill to Brewer.

Dr. A. J. Hammond, now at the Eastern Maine General Hospital, will open an office at Brewer about July 1st.


Dr. R. W. Foster, who has been practicing in Brewer for some years, is now located in Bucksport.

Dr. K. B. Tracy has opened an office at Mars Hill.

FOREIGN BODY IN THE LARYNX.

A very odd case was exhibited at a recent meeting of the section of Laryngology and Rhinology of the New York Academy of Medicine. The patient had consulted several expert laryngologists for some defect in his voice. No one succeeded in producing any improvement, until a certain one, more sharp sighted than the others, discovered a ten cent silver piece lodged between the true and false vocal cords and successfully withdrew it from that strange savings bank.

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The need of many children for cod-liver oil has been met with marked success by Hydroleine. They take it willingly; they—as well as adults—like its distinctive nutty flavor. Hydroleine is also exceptionally digestible. While its scope of usefulness is widened by its palatability and digestibility, it is always notably dependable.

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 115 Fulton St., New York
 Sample will be sent to physicians on request.

Book Reviews.

Medical Men and the Law.

By Hugh Emmett Culbertson. Published by Lea and Febiger.

This book was reviewed in the April issue on page 1301, but by some oversight the names of the author and the publisher were omitted.

FOR SALE— \$3,000 established practice in pleasing country village on railway. May easily be increased by good man. New house and stable, independent water supply, hot and cold water, bath room and furnace, acre of land, all for \$5,000.00, part cash. Considerably less than cost. Short drives. Address **A. B. C.,** Care of MAINE MEDICAL JOURNAL PORTLAND, MAINE

Typhoid in Large Cities.

There were fifty cities of over 100,000 population in the United States in 1910 containing over 22 per cent of the population of the country. Dividing these cities into groups according to population, the death rate from typhoid, as shown by a recent report in the Journal of the American Medical Association, is as follows:

TABLE 1.—DEATH-RATES FROM TYPHOID IN CITIES OF
GROUP 1 (POPULATION OVER 500,000).

	Deaths from Typhoid per 100,000 Population		Average 1906 - 1910
	1912	1911	
Cleveland	5.9	14.7	16.5 (5)
Chicago	7.5	10.8	15.5 (2)
Boston	8.1	9.3	16.0 (3)
New York	9.8	11.1	13.8 (1)
St. Louis	10.4	15.4	16.1 (4)
Philadelphia	12.5	14.1	42.1 (7)
Pittsburgh	12.7	25.8	74.3 (8)
Baltimore	23.9	27.2	34.6 (6)

The most striking fact with respect to the group of our eight largest cities is the great reduction that has occurred in the typhoid rate in Philadelphia and Pittsburgh. Both of these cities have recently installed sand filters for their water-supplies, and the low typhoid rates in 1911 and 1912, as compared with preceding years must be attributed chiefly to the diminution in the amount of water-borne typhoid.

Baltimore has a typhoid rate nearly twice as high as that of any other city. Even in Baltimore, however, marked improvement seems to have taken place following the treatment of the water-supply with hypochlorite beginning January, 1911. In 1912, the typhoid rate was the lowest in the sanitary history of the city.

TABLE 2.—DEATH-RATES FROM TYPHOID IN CITIES OF
GROUP 2 (POPULATION FROM 300,000 TO 500,000).

	Deaths from Typhoid per 100,000 Population		Average 1906 - 1910
	1912	1911	
Newark, N. J.	7.1	10.3	14.6 (1)
Cincinnati	7.5	11.7	30.0 (7)
Buffalo, N. Y.	11.4	25.1	22.8 (3)
Minneapolis	11.5	11.6	32.2 (8)
New Orleans	14.0	30.7	35.6 (9)
San Francisco	14.1	15.6	27.3 (6)
Los Angeles	14.6	12.6	19.0 (2)
Detroit	17.1	15.6	23.4 (4)
Washington, D. C.	21.2	20.9	36.9 (10)
Milwaukee, Wis.	25.3	19.3	27.0 (5)

The marked improvement in the water-supply of Cincinnati is reflected in the lowered death-rate from typhoid fever in that city for 1911 and 1912. Minneapolis, also, shows in its lowered death-rate the probable effect of the use of hypochlorite on the city water-supply. Detroit, as well as Milwaukee, should take action in respect to its water-supply. In 1896-1900, Milwaukee and Detroit had the lowest typhoid rates in this group of cities; now their relative position is among the worst. They may well contrast their typhoid-fever death-rates with those of the lake cities that have pure water supplies.

TABLE 3.—DEATH-RATES FROM TYPHOID IN CITIES OF GROUP 3 (POPULATION FROM 200,000 TO 300,000).

	Deaths from Typhoid per 100,000 Population		Average 1906-1910
	1912	1911	
Seattle, Wash.....	7.4	9.4	25.2 (6)
Jersey City, N. J.....	7.5	6.2	12.6 (2)
St. Paul, Minn.....	10.2	10.0	18.0 (4)
Providence, R. I.....	10.3	12.2	14.3 (3)
Rochester, N. Y.....	11.8	10.3	12.4 (1)
Kansas City, Mo.....	12.8	23.7	35.6 (9)
Denver	13.0	17.6	35.5 (8)
Portland, Ore.....	16.9	17.8	23.3 (5)
Indianapolis	18.3	26.2	30.4 (7)
Louisville, Ky.	18.9	25.6	52.6 (10)

Marked improvement in typhoid-fever rates is shown by every city in Group 3. Especially noteworthy is the case of Louisville, where the typhoid rate has fallen steadily since 1907, a circumstance that may be attributed largely, if not solely, to the improvement of the public water-supply.

TABLE 4.—DEATH-RATES FROM TYPHOID IN CITIES OF GROUP 4 (POPULATION FROM 125,000 TO 200,000)

	Deaths from Typhoid per 100,000 Population		Average 1906-1910
	1912	1911	
Paterson, N. J.....	4.6	21.2	19.3 (3)
Worcester, Mass.....	6.6	6.7	11.8 (1)
Scranton, Pa.....	8.7	12.0	31.4 (6)
Oakland, Cal.....	9.0	12.6	21.5 (4)
Richmond, Va.....	16.2	17.4	34.0 (7)
Syracuse, N. Y.....	16.8	15.7	15.7 (2)
Columbus, Ohio.....	20.2	13.8	40.0 (10)
New Haven, Conn.....	24.5	23.4	30.8 (5)
Toledo, Ohio.....	33.0	22.6	37.4 (9)
Atlanta, Ga.....	35.2	55.8	58.5 (11)
Memphis, Tenn.....	56.2	61.2	35.3 (8)

Group 4 comprises several cities with very low and several with very high rates. Two cities (Syracuse and Memphis) have a higher

average for 1911 and 1912 than for 1906 - 1910. Memphis has the unenviable distinction of maintaining for the past two years the highest rate from typhoid fever of any large city in the United States.

Attention is also especially directed to New Haven, where the typhoid rate has been excessive for the last seven years.

The citizens of Toledo may perhaps ask themselves why the typhoid rate in that city in 1912 should be five times as great as the rate in Cleveland. On the other side may be mentioned such very encouraging conditions as apparently exist in Worcester, Mass., where a very low typhoid rate has been maintained for two consecutive years, and the remarkable improvement that has been brought about in Richmond, Va.

TABLE 5.—DEATH-RATES FROM TYPHOID IN CITIES OF GROUP 5 (POPULATION FROM 100,000 TO 125,000)

	Deaths from Typhoid per 100,000 Population		Average 1906 - 1910
	1912	1911	
Cambridge, Mass.....	2.8	4.7	9.8 (1)
Bridgeport, Conn.....	7.4	3.8	10.2 (2)
Lowell, Mass.....	9.2	6.5	13.9 (4)
Hartford, Conn.....	12.7	19.8	18.9 (6)
Omaha, Neb.....	13.2	45.1	40.8 (8)
Spokane, Wash.....	16.9	38.5	50.4 (9)
Albany, N. Y.....	17.7	17.8	17.5 (5)
Fall River, Mass.....	18.8	15.8	12.5 (3)
Nashville, Tenn.....	30.1	52.0	61.2 (10)
Grand Rapids, Mich.....	34.0	26.1	29.7 (7)
Dayton, Ohio	*	18.3	22.4

* No answer received from health department.

Three cities in Group 5 (Grand Rapids, Fall River and Albany) show no improvement in their typhoid rate for 1911 and 1912 over the preceding five years (Table 5). In view of the general trend of typhoid-fever rates in this country this should cause some searching of heart among the inhabitants of the last two cities named. Cambridge, Mass., has the lowest typhoid average for 1911 and 1912 of any city in the country, thus keeping the place it held in 1906 - 1910.

The only cities with a higher average typhoid rate in 1911 and 1912 than in 1906 - 1910 are Memphis, Tenn., Syracuse, N. Y., Grand Rapids, Mich., Fall River, Mass., and Albany, N. Y.

Cities with an average typhoid death-rate in 1911 - 1912 below 10 are Cambridge, Mass., Bridgeport, Conn., Worcester, Mass., Jersey City, N. J., Lowell, Mass., Seattle, Wash., Boston, Newark, N. J., Chicago and Cincinnati.

But one city in the whole fifty-one (Cambridge, Mass.), had an average below 10 for the five years, 1906 - 1910.

Journal A. M. A.

County News.

KNOX.

A special meeting of the Knox County Medical Society was held in Rockland on May 19th.

Dr. Frederick Lund of Boston, read a very interesting paper on "Empyema."

It was a great privilege for us to be able to have such an able man with us, and the number present was unusually large.

At the regular June meeting, Mr. Evans of the laboratory of hygiene is going to give us a paper on laboratory work.

H. W. FROHOCK, *Secretary*.

HANCOCK.

Meeting held at the residence of Dr. E. J. Morrison, Bar Harbor. Dr. Frank R. Ober, the president, in the chair. The meeting was called to order, and the minutes of the last stated meeting read and accepted.

Four names, having been approved by the census, were voted on and accepted to membership.

Dr. J. D. Phillips was elected alternate delegate to the annual meeting of the Maine Medical Association.

By invitation, Dr. Harold H. Crane of Bangor, read a paper entitled: "Treatment of Cancer of the Uterus." The paper was well discussed by nearly every one present.

There were present fourteen members and two guests. The meeting was one of the most successful of the year.

We adjourned to the banquet room where we were well and sufficiently entertained by our most genial host, Dr. E. J. Morrison.

FRANK R. OBER, *Secretary*.

Wild Oats: A Medical Commentary.

Some time ago, the "Spectator" contained numerous letters upon this topic of so extreme value to young men, and one of them from a medical point of view was so unique that we venture to print it nearly as it was handed in to the "Spectator."

Recent correspondence, in the "Spectator" on the sowing of wild oats will be none the worse for a medical commentary. Here comes the doctor. He has nothing to say about the ethics of literature but he does know something about the sowing of wild oats and what is more, he knows something about the reaping of them.

Let us take the point of view of physiology. Is it true to say that abstinence is harmful? The sower may like to think that it is, but where is his evidence? Can he show us any cases of the bad results of such abstinence? Has he ever heard on good authority of any harm done thereby to any man? Has he ever come across a man invalided or run down as the result of chastity? Is the sower's creed: "I believe that chastity may injure a man's health," true or false?

There is plenty of evidence that it is false. Many of their patients, Sir James Paget told his students, would ask them about sexual questions, and some of them would expect them to prescribe immorality. I would as soon prescribe theft, or anything else that God has forbidden. "We are not to advise that which is morally wrong, even if we have some reason to think that a patient's health would be the better for the wrong doing. But in the case before us, there is not ground enough for so much as raising a question about wrong doing. Chastity does no harm to mind or body, its discipline is excellent." Sir James went on to say that among the many nervous patients who had talked to him, he had never heard one say that he was better or happier for immoral practices. If immorality be useless or worse than useless in such cases, it cannot be necessary for the health of young men who have nothing the matter with them.

"I have not the least hesitation in saying that sexual intercourse is neither necessary for health, nor for the preservation of fertility," says another eminent physician. "So far as we know in man, and can judge by animals, both ideas are entirely untrue."

Sir Dyce Duckworth declares that from the aspect of physiology and good medicine, "it is not necessary for any young man to adopt immoral courses." Dr. Bezly Thorne declares that in the course of 35 years of practice, he had never met with a young man who had suffered in any way as the result of abstinence. It would be easy, if these few statements were not enough, to collect a hundred more. The belief that by this abstinence a man's bodily vigor may be impaired is false. If a man attributes his want of complete fitness to his want of indulgence, let him try more sleep and fresh air, less alcohol, meat and tobacco, and more exercise and occupation.

As a matter of fact a young man committing for the first time an act of immorality is not thinking about his health. He knows that there is nothing the matter with him. He does what he does because he has made up his mind to have at all costs a certain pleasure and a certain experience. He has persuaded himself or has been persuaded by others, that he is entitled by nature to them: he has been waiting for them ever since he was born. From insect up to man, all life de-

pende on this exercise of sex. Why is he what he is if he is not to have the experience? What else is all life about? Is he not, as things are, less than a man?

His pride cries out under this insult. He cannot bear this ignorance. It torments to be among men who know and understand what he does not. He plays with their vocabulary as a baby plays with the belongings of grown up people. And what is harder to endure than ignorance, all sorts of physical promptings come to him till it seems to him less clean, less gentlemanly, to have these, than to have what they suggest to him. At last he goes wrong; not from any desire for more health, nor from any compelling passion, but from sheer hatred of his ignorance, his inexperience and his incompleteness.

That is to say: his behavior is not that of an animal, but of a complex minded and self conscious young man. It was not instinct with him, it was elaborate argument.

So much for him, now for his opposite, the young man who keeps straight. It is not to be doubted that the number of these is much greater than it was fifty years ago. Some find it easy, and some find it hard. The point is, that none of them does anything to maintain the wreckage of the women on the street.

So, too, the man who keeps straight has the advantage that he neither gets nor gives disease. That is how wild oats are reaped. Every town is saturated with these diseases, our hospitals reek with them, our asylums for the blind and the deaf mute are full of the results of them. Young men in such conditions are not nice; they are infective creatures; they are septic; they carry and spread infection.

The prose of wild oats is just as true as the poetry of them and truer; and they that sow in joy shall reap in tears. Poets forget the contagious legions of men who crowd the out-patients departments or waste their earnings on quacks. It has been calculated that every girl who goes on the streets becomes infected with a constitutional disease within six months. That prospect is not favorable for the sowing of wild oats!

A poet, a woman, by the way, wrote not long ago that youth is a sufficient excuse for "A thousand nights of sin." It would do her good to attend any out-patient department till she had seen not one youth after a thousand nights, but a thousand youths after one night of sin.

The young man who keeps straight is, it is true, devoid of one of life's experiences, but he has his reward. He can say to himself that he has not contributed to any woman's ruin; he is absolutely healthy and wholesome; he is untainted with disease, and when he marries, he will neither infect his wife, nor beget tainted children.

(Signed) "A HOSPITAL SURGEON."

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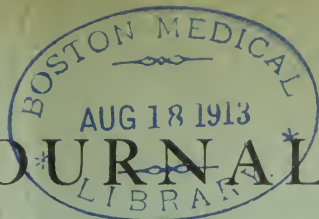
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CHRONIC INTESTINAL STASIS.†

By WILLIAM SEAMAN BAINBRIDGE, A. M., Sc. D., M. D.

Professor of Surgery, N. Y. Polyclinic Medical School and Hospital.

The work of W. Arbuthnot Lane,* of London, has opened a distinctly new line of investigation with regard to a large class of maladies associated with impaired function of some part of the alimentary canal and of organs closely related thereto. General auto-intoxication, chronic constipation, visceroptosis, floating kidney, gall-stones, duodenal ulcer, mucous colitis, pericolitis, chronic appendicitis, and other conditions traceable to perverted function of these parts of the organism, must now be studied from a different point of view from that which has been brought to bear in the past. Lane has pressed forward in the effort to discover first causes, and in doing so he has demonstrated clearly that in health maintenance the question of prime importance is body-drainage — the non-absorption of poisons, and the elimination of whatever poisonous matter may be produced within the alimentary canal, before there has been inaugurated a vicious cycle of events which may be the forerunner of disastrous end-results. Attention has thus been focussed more directly upon the previously obscure phenomena of intestinal stasis, and a plausible explanation has been offered of the causes underlying the evolution of these phenomena.

*In June, 1913, for his great contribution to surgery, Mr. Lane was created a Baronet.

Lane has demonstrated to his own satisfaction and to that of a large number of surgeons, in Europe and America, that intestinal stasis, as he calls this slowing of the drainage current, is the result of the abnormal fixation of certain portions of the canal, with a dropping of the tube on either side of the fixed point, thus producing a kink. The kinking of the intestine prevents the free passage of its contents, causes a "puddling" in the dependent portions, a damming back and infection of the material and a general slowing of the drainage. His definition of this state of affairs, this "chronic intestinal stasis," is: "Such an abnormal delay in the passage of the intestinal contents through a portion or portions of the gastro-intestinal tract as results in the absorption of a greater quantity of toxic or poisonous materials than can be treated effectually by the organs whose function it is to convert them into products as innocuous as possible to the tissues of the body." This reabsorption and auto-intoxication, according to Lane, leads to a general lowering of the resistance of the body and to the concomitant increase in susceptibility to various diseases. This increased susceptibility, in his opinion, finds an expression in various conditions to which he has applied the term "end-results." His view, it will be noted, is thus the direct antithesis of that of many other observers, who consider such diseases as causative factors in the production of chronic intestinal stasis. Notable examples of what Lane has diagnosed as "end-results" are: cancer of the stomach, intestine, biliary ducts, or pancreas; visceral tuberculosis; rheumatoid arthritis.

The explanation offered by Lane for the conditions which lead to chronic intestinal stasis is a purely evolutionary one, as opposed to the hereditary, congenital and toxic theories held by others who have made a study of intestinal obstruction in general. According to Lane, the toxic symptoms are secondary; others hold them to be primary or causative of the mechanical changes which produce stasis.

The ptosis of the abdominal viscera, according to Lane's theory, is, broadly speaking, the result of the assumption, by man, of the upright position. In early life, this ptosis is the result of an abnormal distention of the intestine, consequent upon too frequent feeding, or upon the continued use of an unsuitable diet. In later years it is brought about or accentuated by the erect posture which man assumes during the waking hours. The resulting pressure and strain may produce distinct changes, which may take the form of *evolutionary bands*, as Lane calls them. These bands are practically without blood supply, and are not to be confounded with *inflammatory adhesions*, which are apt to have a generous blood supply. These evolutionary bands exist primarily for the advantage of the individual,

for the purpose of supporting the intestines and preventing them from dropping downward. These bands do not develop with equal strength throughout, unfortunately, and as a consequence the bowel is held up firmly in some points and allowed to sag in others, the result being the angulation, or kink, at the point of support.

The formation of these evolutionary bands leads to kinking of the intestine at certain points of predilection, as demonstrated by Lane: (1) pylorus; (2) duodeno-jejunal junction; (3) different points along the terminal coil of the ileum; (4) appendix; (5) hepatic flexure; (6) splenic flexure; (7) sigmoid flexure; (8) rectum.

The symptoms which result from chronic intestinal stasis vary in different individuals, with the degree of obstruction, and with the concomitant "end-result" manifestations. They may be briefly catalogued as follows: (1) Headache, severe and frequent; (2) nausea, followed by retching or vomiting; (3) anorexia, almost constantly present; (4) loss of weight; (5) coldness of extremities; (6) mental apathy; (7) constipation; (8) foul taste in mouth, often accompanied by foul breath, carious teeth, and furred tongue; (9) abdominal distention, relieved by eruction, the passage of flatus, or an action of the bowels; (10) abdominal tenderness over the areas of fixation; (11) skin-staining; (12) breast changes, simulating chronic mastitis, in the early stages, and cystic degeneration in the later stages; (13) general muscular pain and more or less marked stiffness of joints.

Stasis cases have been classified, according to predominant symptoms, under the following types:

(1) *Obstructive*. These have usually been regarded as having duodenal ulcer, cancer of the stomach, or "nervous dyspepsia."

(2) *Toxic*, in which the symptoms range from occasional "bilious attacks," through the various types of "indigestion," "atonic constipation," to neuroses of divers kinds.

(3) *Mixed Type*, presenting symptoms of the obstructive and toxic types.

(4) *End-result type*, comprising such affections as intestinal cancer, gall-stones, tuberculosis, rheumatoid arthritis, Still's disease, etc.

The diagnosis of chronic intestinal stasis is made by the clinical symptoms, plus careful radiographic study, the degree of obstruction and the location of the obstructing kink being determined by the rapidity of the passage through the intestine of bismuth.

The treatment depends upon the degree of stasis. In atonic or asthenic individuals, where there is general loss of muscular tone and nervous energy, with only slight degrees of ptosis of the hollow viscera, complete cure may be effected by means of abdominal supports, tonic

regime, building up the nutrition, and rest, until nerves and muscles have regained their normal tonus. Liquid paraffin (oleum mineralis Russicum) given in from $\frac{1}{2}$ to 1 ounce doses two or three times a day on an empty stomach, has been found particularly helpful in this class of cases.

It is held by Lane and his followers that in the vast majority of instances, intelligent management by the internist will prevent chronic intestinal stasis, and that the milder degrees, promptly recognized and carefully treated by the measures outlined, may be cured without recourse to surgical measures. Once allowed to progress, however, to the more marked degrees of stasis, with definite kinking, and with clearly characteristic symptoms, surgery must be brought into requisition. The extent of the operative interference must be contingent upon conditions found upon laparotomy. In some cases, the cutting of the evolutionary bands, and the restoration of the angulated or misplaced hollow viscera or other organs, to their normal position, will effect the return of normal function and the disappearance of the symptoms. In other cases, particularly where broad bands are formed, with adhesions between different portions of the gut, with possible involvement of other organs, such as ovaries, gall-bladder, liver, etc., it is necessary to resort to ileocolostomy (Lane's "short-circuiting" operation), or colectomy.

†Abstract of paper, with lantern slide demonstration, presented before the Cumberland Medical Society, April 19, 1913.

PRIMARY LUES AND THE DARK FIELD.

By DR. BENJAMIN B. FOSTER, PORTLAND, ME.

Lues was not known or at least was not recognized in Europe, until towards the end of the 15th century. Two views are taken of the apparent origin of this disorder. One explains the first epidemic of Europe as of absolutely American origin, a deportation of the germ from the West Indies by the sailors of Columbus, and an extension thereafter in consequence of the commingling of nations in the campaign in Italy.

The other takes the ground that the epidemic succeeding the discovery of America, was merely an awakening to activity of the germs of a disease which had been unnoticed up to that date, because of its limitations.

The first one to describe an organism in luetic lesions was Donne, who, in 1837, found a spiral organism to which Muller gave the name "*Vibrio Lineola*."

Bassereau in 1852, separated definitely the venereal sore from the true luetic chancre. From that time on, research in lues was very active, and the discoveries of the causative organism were announced year after year from different quarters, only to be disproved after a time.

In 1903, Mechnikoff and Roux were successful in the transmission of luetic lesions to higher apes. This opened a wider field by furnishing a means of studying the nature of the causative agent outside of human subjects. Thus it was learned that the virus of lues does not pass through a filter and does not therefore belong to an ultra-microscopic organism.

In 1905, the organism that was destined to gain universal recognition as the long sought for virus, was first viewed by Schaudinn and Hoffman. Schaudinn found in the aspirated fluid from a swollen inguinal gland of a luetic, a faintly visible, extremely delicate, small spirochæta. This organism stained faintly with Giemsa's solution, was paler than any spirochæta known to him at that time, hence he gave it the name *spirochæta pallida*, renaming it the same year *treponeema pallidum*.

Lues is essentially a disease of the blood vessels and lymphatics, and a vast majority of the lesions due to the disease, are due directly or indirectly to the effect of the disease upon the blood vessels. The lesions show the character of an infective inflammation. This is seen in the alteration of the walls of the vessels, arteries and veins, and causes a cellular infiltration around them composed chiefly of plasma cells. The tumorfaction which constitutes this infiltration is more or less circumscribed, and in primary and secondary stages is capable of more or less restitution and resorption, the initial lesion rarely leaving any scar.

In the initial lesion the inflammation of the dermis is close and tense, the cells are packed and pressed into the area involved, the connective tissue fibres of both papillæ and corium are swollen. The blood vessels show a very pronounced infiltration of their walls. The epidermis is thickened at the sides of the lesion, and, at the center, several of the upper epidermal layers have disappeared, while those remaining are filled with leucocytes and fibrin and are degenerating.

The spirochætæ are found crowded about the blood vessels and seem to emigrate from these into the tissues, as well as farther into the vascular system. They penetrate into the connective tissue fibres and spaces between them, and from this point enter the lymphatic

system and are carried to the glands of the region, this accounting for the typical lymphatic engorgement. Finally the spirochætæ enter the epiderm by going upward through the basal membrane and appear on the surface, from which point they may be transmitted.

The lesions of hereditary lues do not differ very much from ordinary luetic lesions, but contain even more spirochætæ.

There are numerous methods of staining this organism, but the disadvantage with all the staining methods is that not only do most of them consume a considerable amount of time, but also to differentiate between the spirochæta pallida and other nearly related and morphologically similar organisms is much more difficult in the stained preparation than in the dark-field preparation.

For dark-field work, the microscope must be equipped with a dark-field converging lens in place of the ordinary converging lens. This allows no light to pass directly through the specimen to be examined, but gives a cross light ray illuminating the specimen against a black background.

The 1-12 oil immersion objective must have a special cone installed which eliminates the diverging rays that tend to blur the reflection.

The preferable light to use is a small electric arc having a converging lens which will reflect a strong ray of light upon the reflecting mirror of the microscope.

Several slides and cover glasses are cleaned and made ready for use. A platinum loop is rendered sterile and the material for examination is obtained by gently scraping the lesion with the platinum loop and obtaining serum preferably without blood. The serum is placed upon a slide and a cover glass quickly and firmly pressed down, several specimens being obtained. The operator should then place a drop of cedar oil on the dark-field converging lens, place the slide on this, and then another drop of cedar oil on the cover glass, bringing the 1-12 objective down into the last drop, thus causing one unbroken airless transparent body.

The spirochætæ may be recovered from the primary sore, skin lesions, mucous patches, and from the fluid obtained from the glands draining the primary sore. The organism has been recovered from skin rashes, and frequently from skin lesions, but one will have far better success by taking his smears from the primary sores and lesions of the mucous membrane.

It is absolutely essential that the lesion to be examined is free from treatment with any mercurial ointment and dusting powder, or by cauterization, for this local treatment will generally render the search for spirochætæ useless. No mercury should be prescribed at

this time, before the diagnosis has been made, and the patient should be cautioned not to use any alcoholics whatsoever, as the mercury and alcohol may vitiate the result of the Wassermann. Frequently it is necessary to obtain irritation serum from the deeper layers, avoiding surface contamination. To do this the lesion is carefully cleaned with sterile normal saline solution on a cotton swab, slightly irritated with a dull curet, and if necessary a vacuum cup or heated test-tube may be used to start the serum flowing.

The *spirochæta pallida* of lues, has regular deep curves and is a finely and evenly spirile body actively motile. There are normally other *spirochætæ*, those of the buccal cavity, macrodenticium and microdenticium, also on the healthy genital organs, refringens.

The *spirochæta pallida* of lues, has regular deep curves and its movement is rotation.

The *spirochæta microdenticium*, which morphologically is most apt to be mistaken for the *pallida*, has regular, fairly deep curves, and a rotary movement, but is a smaller organism. The *spirochæta macrodenticium* is not apt to be mistaken. The curves are less regular, longer, flatter, much thicker, and wider. Its motion is vibratory and rotary.

The *spirochæta refringens*, normal on the healthy genitalia, is not at all likely to be mistaken for the *spirochæta pallida*. Its curves are irregular and its movements are wavy and serpentine.

The examination for *spirochæta pallida* is not a difficult procedure, and those of the profession who see many suspicious cases, should become familiar with the dark-field method. Since the discovery of the *spirochæta pallida*, the early diagnosis of lues has become a most important point in its treatment. An early diagnosis cannot be made with any certainty on clinical grounds alone. No suspicious sore suggesting a primary lesion, should be considered positively or negatively luetic until so proven by clinical observation in conjunction with repeated use of the dark-field.

Long Interval between Birth of Twins.

The British Medical Journal of April 26th reports from the practice of Dr. Postheltwaite of Whalley, an instance in which a living male child was born February 24, 1913. The mother went to work in a fortnight and on April 4th, labor pains again ensued and she was safely delivered of a living female child. Both children weighed about 6 pounds and at latest reports both were doing nicely.

Perhaps our readers may be able to report a similar case of at least considerable intervals between the births of twins.

THE RELATION OF THE CHURCH TO MEDICAL SOCIAL SERVICE.

A. A. DOWNS, M. D.

Executive Secretary of the Maine Anti-Tuberculosis Association and Medical Director of the Central Maine Sanatorium, Fairfield.

Read before the Y. M. C. A. of Bowdoin College, February 13, 1913.

It would have been a comparatively easy thing for me to have entertained you this afternoon with the relationship of the church and medicine in ancient and mediæval times. It would have been a pleasure for me to have given you a short biography of some of the leading physicians who have been church men, and who have done marvelous things for the world's progress. I could have taken you back to the time when the priest was the physician, to the time of mysticism and astrology, and showed you how during the centuries since, the priest and the physician have become separated and the profession of medicine has become organized, and a valuable agency for the world's progress. What I should have told you, you could have learned from the church and medical histories in your own library, and I shall confine my talk to the question of how the church and medicine can work together for the greatest good of humanity in the present age. This is an intensely practical age, and a paper upon a subject of this nature, must deal with the practical problems of life as we find them in our State and nation.

In an analysis of my subject, I am of the opinion that by church is meant that great body of people who are attendants upon the church of God, taken either collectively or individually; and by medical social service, I presume is meant that social service of a medical nature which will reach the largest number of people in a community, whether the nature of that service be the opening of a free dispensary, the employment of a district nurse, the furnishing of free supplies and other means of controlling a preventable disease; or whether it be influencing public opinion for the better enforcement of hygienic laws or legislation for the purpose of securing these laws; and it is upon the basis of this assumption that my paper has been written.

Personally, I can have but little sympathy with the feeling expressed by many ecclesiastics that the pulpits of our country should be held absolutely for the preaching of the "word of God." I believe that the "word" can be preached in a sermon devoted to social service which will lift up "fallen man" as much as by a straight spiritual sermon. If I can read my Bible correctly, I find that our great Teacher when he was on earth did not stop at preaching only, but healed the

sick, restored the blind, fed the hungry and did all kinds of what in this day would be called social service work; and until the churches of this country are awakened to the fact that there is something more in the religion of Jesus Christ than simply the preaching of a spiritual sermon on Sunday, just so long will our churches be empty of men. One of the most difficult men to reach by a pastor or an evangelist, is one who is himself or some member of his family suffering from a preventable disease, who is barely earning enough money to cover the actual necessities of life, and who perhaps has known of some member of a church in his town with unlimited means, who has refused to assist in the relief and control of the disease from which he is suffering. That man can be reached much quicker, providing that he knows that the church, which this pastor serves, is interested in social welfare work, that the members are supporting a work of this kind, and instead of bringing him figuratively the "bread of life," that church brings him the actual "bread of life." I question very seriously whether many men living under these conditions were ever brought into a true Christian life.

One of the leading medical men in America today, said in an address recently that he believed that it was only when the church awakened to the social problem, that they would be doing the greatest good to humanity and I am fully confident that the present Christian church in America has departed a long way from the teachings of Christ and his instructions given to the disciples.

RELIGIOUS PRESS.

The religious press of this country are prostituting their pages weekly by publishing advertisements for financial returns only, that are a disgrace to the country. If you pick up almost any religious journal, you will find advertisements ranging anywhere from magic plasters for the cure of rheumatism to be applied to the soles of the feet, to colored water for the cure of consumption, and artificial ear drums for those who are stone deaf. The writer sometime ago called the attention of the editor of one of our leading religious journals, to an advertisement purporting to be a cure for asthma, and which had been investigated by the Commission of Pharmacy of the American Medical Association, and found to be an unqualified swindle. The editor replied, stating that he knew the man who advertised this patent medicine, that he was a prominent church man, and that he was absolutely certain it was a genuine thing and would cure asthma. He further stated that he knew exactly how the medical profession felt about this matter, as there was a physician in his family and it was a question of frequent discussion. Others have been more frank than

this man, stating that while they knew it was a rank swindle, it was necessary to publish this advertising or suspend the publication of their paper, because this was their largest source of income. What a libel upon the Christian people of America today, when it becomes necessary for a religious journal to publish the advertisements of a fraud in order that they may meet expenses. One of the religious quarterlies has for years published patent medicine advertisements, and one of them purporting to be a cure for rheumatism has occupied considerable space: and as it is published year after year, it must be a good paying advertisement for the owners. This same medicine has been proven time and time again to be nothing but is well known to the medical profession of this country, and which no reputable physician would for one moment advertise as a cure. The editors of this quarterly had their attention called to the matter sometime ago, and they stated that it would be impossible for them to discontinue this advertisement.

TESTIMONIALS.

It is a well-known fact that patent medicine is sold largely through the testimonials of those patients who have taken the medicine and are of the opinion that it has been of value, or else from unscrupulous people who have sold their names for financial returns. There is nothing that a "quack" so delights in as a testimonial from some clergyman or noted church attendant. Perhaps, many of you will remember the advertisement of a malt whiskey a few years ago, in which the testimonial of a clergyman was given, and which was proven later to be false. *Colliers* has repeatedly called the attention of the citizens of this country to the falsity of these testimonials. To me, there is nothing so degrading or more criminal than to deprive the people of this or other countries of their health, and many times of their life, through the influence of a man or woman who pretends to lead a Christian life. The churches of America, both as individuals and collectively, have a stain upon their fair name which only years of active Christian social work can remove, and it certainly is time that the church should awaken to this problem. I believe it to be the duty of the pastor of every church to call the attention of his congregation to this practice which is blighting the fair name of our country.

PUBLIC HEALTH WORK.

Looking at this question from both the standpoint of the church attendant and of the physician, I have felt for a long time that there was an active work for the churches to do in our State. The citizens of Maine are conservative and rather slow to awaken to new ideas,

especially along public health lines. Maine is in the rear of many other States in dealing with public health problems, and it is only as the church people become interested in medical social work, that these conditions will be changed. The future of medicine is undoubtedly preventive medicine, and the greatest good at the present time can be accomplished by preventive measures. The medical profession are a philanthropic, unselfish body of men, giving of their time and money for the care of the sick, receiving pay in only a certain percentage of cases, ready for the call of duty day or night, and many of the most noble heroes whose names are honored have been members of the medical profession, who have given up their life in order that the world should be benefitted thereby. However, the medical profession alone can not control disease, and it is only when such men as Rockefeller will give their millions to establish experimental institutes, and the citizens at large will give their dollars to carry out these projects, that we shall be able to put the practice of medicine upon a scientific preventable basis.

PROHIBITION.

In the present Massachusetts legislature, a bill has been introduced, which aims to classify the habit of intoxication as a disease, and asks for State care for these cases. Last fall at the Inter-National Congress on Hygiene and Dermography, a symposium was given on this subject with papers by men in this country and from abroad, who showed conclusively that the habit was a diseased process and should be treated in special sanatoriums. What a wonderful chance for the church! For years they have made a fight for temperance on moral lines. If we can now make a fight on physical lines, one of the greatest opportunities of the century has come to the church men.

SEX PROBLEM.

The question of the sex problem and social purity is a medical and religious problem so closely bound together that they are inseparable. The teaching of sex hygiene in our schools must come. Our children need a more complete knowledge of their bodies before they are turned into the world to learn of these things from idle and dissolute companions. The conscientious tactful physician must co-operate with the mother in the home and the pastor in the church. It is undoubtedly true that the largest percentage of operations performed upon the females of this country are caused by gonorrhœa, and syphilis has blighted the life of many an unborn child. It is not every man or woman, and certainly not every physician or pastor, who can talk to the

children about the sex problem. It requires tact, a knowledge of their subject, and simple modes of expression; and it is a part of the duty of the church and medical profession working together, to find these people and support them in their work. The prostitutes in this country, numbering hundreds of thousands, are a grave source of danger to our children, be they male or female, and this problem also must be handled by the church and medicine working hand in hand. No man or woman, with but a few exceptions, who have been taught sex hygiene during their childhood, but what will refrain from intercourse with an infected person. Physicians working in homes, such as the Florence Crittendon Home, must have the moral and financial support of the large body of religious people. This paragraph is not a charge of guilt against the women, as multitudes of them are the innocent victims of their husbands' combined sin and ignorance.

EUGENICS.

The subject of eugenics is coming to the fore, and within the next few years a great deal will be heard regarding this matter. It is one of the important measures for the future health and prosperity of this country, and it should be handled in a sane, conservative way. The physicians themselves will never be able to work out these problems, and it is only as we can have the assistance of the church that the best work can be done.

PREVENTABLE DISEASES.

Preventable diseases are causing an immense financial loss, and hundreds of thousands of lives are sacrificed every year in the United States of America. Every one of these diseases could be prevented and can be eradicated from the world. The results obtained from the typhoid vaccine in the United States army is convincing, and before long nearly everyone who is in any way exposed to the dangers of typhoid will probably receive immunizing doses. This, however, is rather advanced at the present day, and it is only as our State legislatures and municipal governments can be convinced of its value, that money will be appropriated for the work. As vaccine has prevented small pox, so we confidently believe that typhoid vaccine will prevent typhoid. The medical profession alone can not secure the passage of these laws, and here again we must depend upon the large body of Christian citizenship. The hook worm disease and pallsagra in the South, all call for the co-operation of the church and medicine.

INSANITY.

In the dark ages, the insane persons were looked upon as possessed of demons, and were frequently left in huts without food or fire, or some other method of punishment was adopted. Today, in all parts of the world, splendid buildings have been erected by the State or individuals for the care of these unfortunate people. Vast experimental work has been done, but the common people have not the knowledge of this disease that they should have. Medical schools are not teaching half about this disease. The laity should understand that it can be cured in its earlier stages, and in some forms at later stages. Associations are being organized for education and prophylaxis, but it is only as the communities will support these associations, that they can be successful. Leading neurologists feel very strongly upon this subject and a great awakening will come to this country within a very few years.

NATIONAL CONTROL OF PUBLIC HEALTH.

The church has a wide influence in the molding of public opinion, and when it is used in the interests of public health and morality and to overcome idle and vicious prejudices as related to public health, it is performing a variety of social service work which must rebound to its credit. For years, the thinking people of the United States have desired a National Board of Health, with a Secretary, who would be one of the official advisers of the President. At the present time, the public health of the United States is in the hands of several separate departments, and we are a laughing stock for other countries in our public health service. One of the greatest oppositions that has developed to the establishment of a department of public health, has been the work of the so-called "League of Medical Freedom." It is not true that the American Medical Association have any desire of monopolizing the practice of medicine in the United States, and there are today but very few, if any, reputable regular physicians but what would be willing to consult with physicians of any school who have a regular standing in their particular school of medicine. I want to appeal to you gentlemen today, and to the church men of this country, to assist us in putting the public health of this nation upon a pedestal of its own.

LEGISLATION.

The church can markedly influence legislation for "good" along medical lines, and after this legislation is secured, can assist in enforcing the laws. There are many things needed today in Maine in order to place our State on a level with other States. We should have a more

strict enforcement of our laws regarding promiscuous spitting upon the streets. There should be legislation preventing the use of the "common drinking cup" and of the so-called "kiss of death" shuttle. The hygiene of our railroad trains should be improved, and there is great need of passage of the hotel bill which is now before the legislature. One of the most discouraging things in this State is the fact that so many of our leading men will not obey the simple rules of hygiene. One day recently, I was on an electric car with one of the highest officials in Maine, and he deliberately spat upon the floor. This in a crowded car, and in the presence of those who naturally would look to him as their model for obeying the State laws.

MILK SUPPLY.

Last week a conference of representatives from the different eastern States was called by the New York Milk Committee, to consider improvements of State laws for the control of milk production and handling and for the suppression of bovine tuberculosis.

The relation of our milk supply to the public health of the State of Maine is one that should interest every Christian man and woman within the boundaries of the State, and I am sorry to state that the Governor considered the matter of so little importance that he did not even appoint official delegates from this State. Every one of the eastern States was represented by officially appointed delegates, except Maine and Rhode Island. It is this lack of intelligent co-operation in the control of these public health matters that keeps Maine where she is; and it is only as the church, representing one of the largest, best, the most intelligent body of people in the community, will awaken to these subjects that the men in control of our State government will consider a conference of this kind worth noticing. There is no question that Christian social service is needed in Maine along this line. It was shown conclusively that some of our dairy farms, from which we are receiving our milk, butter and cheese, were in frightfully unhygienic conditions. The employees and milk handlers should be medically examined. The sanitary inspection of human dwellings, water supply, drainage systems and milk houses, shipping stations, factories, etc., should be under the direct control of the State Board of Health, while there should be veterinary inspection of the dairy cattle and sanitary inspection of dairy barns and their surroundings. In other States than Maine these things are under specialized control, to an extent unknown in this State.

BOVINE TUBERCULOSIS.

Bovine tuberculosis is a contagious disease, and it has been proven conclusively that a large percentage of tuberculosis in children is contracted through the bovine tuberculosis germ. If this is so, and if our cows are not being tested as they ought to be tested, and our milk is not being produced under the best sanitary control, what a blight upon the name of any city or town permitting such unsanitary conditions; and what a chance for the church collectively or individually, to use their influence in the control of this disease.

INFANT MORTALITY.

The subject of the milk supply and bovine tuberculosis is so intimately connected with the health of the infants of America, and bears such a close relation to the infant mortality, that I can not leave this subject without speaking upon the relationship of the church to this great branch of medical preventive work. At the present time, where the birth rate in this country from American parents is decreasing at such a marked rate, it becomes a very important question as how best to preserve the health of the babe. The small towns and cities in the State of Maine can not support a dispensary and visiting nurse who will give her time to this work, but it would pay our larger cities, or the large towns where they can unite to form a district, to care for these infants; and what better agency to start the work than the churches of our State. We would not expect that our churches could organize and carry on a hospital ship like the Boston floating hospital, nor would we expect that they would open up large dispensaries or hospitals. The church buildings in the majority of the towns of this State, representing a valuation of hundreds of thousands of dollars, remain closed from Sunday morning to Sunday morning, week in and week out, except for the short time they are occupied for the regular Sunday and week day services, and during this time, our boys and girls are on the streets of our villages and cities, in saloons and brothels, associated with evil and lewd companions.

Our people are dying a thousand a year from tuberculosis. The fathers and mothers in this State are mourning the death of their children from absolutely preventable causes, and they are in ignorance as to the methods of prevention. If it is suggested to the average church man that their buildings could be used as recreation rooms for members of their parish, where they could have proper supervision, and if it is suggested that the basement of that church could be used as a dispensary where these mothers could come and be taught how to care for their children and prevent infection, where our tuberculous

patients could come and learn how to prevent and cure, they would hold up their hands in "holy horror" and talk of the desecration of the church edifice. I do not believe there is a town of any size in the State but what there are one or more physicians who would be willing and glad to give one or two hours weekly to the teaching of preventive medicine, and is there a better place for this work than a church edifice that is erected for the service of man and God? If, in addition to a clinic or a dispensary with a physician in attendance, a nurse or intelligent woman could be secured who would make district calls upon those attending the dispensary, and others who need their help; and this work could be conducted by the combined efforts of the church and community, we should be getting nearer to the millennium on earth.

I have said nothing about the duty of the church in social service work in foreign countries, such as medical missionaries, neither have I said anything about social settlement work from the standpoint of medical men, as no work of this kind is being done for the present in Maine, and with our small cities, I very much doubt if it is necessary or advisable.

HUMAN TUBERCULOSIS.

I trust that I may be pardoned if for the remainder of my paper, I shall take up that subject in which I am intensely interested, and to which I am giving my whole time; tuberculosis, or the Great White Plague and its relationship to the State of Maine. I can not but feel that this problem is one of the most vital in the State at the present time, concerning our physical welfare. It is true that typhoid is causing a great many deaths, but where one person is dying of this disease, tens and twenties are dying of tuberculosis; and while typhoid is an acute disease, it is of but short duration. Tuberculosis is a very chronic disease of many years' duration, and a large part of this time the victims are unable to pursue their daily avocation. In the problem of sex hygiene and of prophylaxis in venereal diseases, it is not a question where death will result directly, and with the present treatment for the cure of these diseases, there is a fair prospect for recovery. In tuberculosis, the outlook is different. At the present time, we have absolutely no specific, and it is only through the trinity of fresh air, good food and hygienic living that we are able to arrest this process. Maine, thus far, has not awakened to the seriousness of this problem. At the present time, she is where the parent State of Massachusetts was fifteen years ago. Maine, thus far, has not seen fit to care for her citizens who are suffering from the Great White Plague. While the annual financial loss to the State is \$8,000,000, yet during the last

year, less than \$25,000 was expended for the control of this disease by public and private contribution. After all, the great cost to the State is not in money, but in the loss of life which ought and could be prevented; and one of the great humanitarian works for the churches of Maine is in the control and eradication of this and other absolutely preventable diseases. It is probable that there are but few families in this State but what at some time have lost some member of the family through this Great White Plague. Caused as it is by a vegetable organism, it is possible to eradicate the disease absolutely, when proper hygienic and prophylactic measures are taken.

The common drinking cup, the promiscuous spitting on the streets, the unprotected food in our grocery stores, our crowded unventilated schools and churches, the close air of our department stores and moving picture theatres, clerks working in ill-lighted and unventilated rooms, the lack of disinfection of houses occupied by tuberculosis patients, the lack of hygienic teaching in our public schools, the indifference of the people on this subject, the lack of interest among our pastors in the State; and above all and beyond all, perhaps, the folly of the State legislature in not appropriating money sufficient to begin this campaign on a scientific basis; all are causes which lead up to our present situation in Maine.

In the eradication of tuberculosis, there are several factors which must be taken into consideration. It is not enough that we should secure sanatoriums and hospitals for the treatment of this disease, but we must follow these cases up in their homes, we must educate the parents and the children in the methods of prevention. It is a public school problem, and must be taught by our teachers in the schools. I venture a prophecy: that within a few years, not only will this matter be taught in the schools, but open air schools will be organized for tuberculous children. Every town and community must be educated up to their duties. They must be made to understand that they are themselves responsible for the spread of this disease, and they have a duty to the State and to their fellows to help in its eradication and its control. This can probably be best brought about through a campaign of education in the different towns, through the organization of local associations, the opening of free dispensaries and the employment of district nurses. In the carrying out of all of these projects, we must look to the church and the church people for their sympathy and financial support.

CONCLUSIONS.

In conclusion, I want to repeat some things that I have already said in my paper, so as to more forcibly impress them upon your minds. The body of people in the State of Maine, to whom we must look for

the carrying out of medical social work and financing such work, are not the Toms, Dicks and Harrys on our street corners, the unemployed, or those who have no interest in God and humanity; but it is those who believe they have a duty to their fellow men, one that can not always be paid in full by check; and this class of people is largely represented by our churches today. In the control of the Great White Plague, we must look to the churches, and must have their intelligent co-operation. In the sex question, while at the present time many people can not see the teachings of this problem as a necessity, yet it must come and it must come through the churches. Our legislation for all hygienic purposes will be brought about only as the churches of Maine will use their influence with the legislature, while in the enforcement of laws already passed, we must depend largely upon the influence of this large body of Christian citizenship. Only recently, I heard a man criticise our churches, saying that he was not an attendant upon the churches and would not contribute to their support, because he felt that the churches of this country were degenerating, that they were not doing as much for humanity as were the lodges to which he belonged, and that he preferred to use his money for the support of the lodges rather than the churches; and his statement is borne out by the attendance of our men in the church services. As I said in the beginning of my address, this is a practical age, it is an age where if men "make good," they must do something for the good of humanity. It is an age where the average man will not support an institution where he can not see any visible results from his contributions. I feel strongly upon this subject. I feel there is something radically wrong in our churches, and I believe one of the solutions of this problem will be: when our church edifices are thrown open to social medical work, when work of this kind is mentioned in the pulpit and taught in the Sunday-school, and the church people will give of their time and money, in order to prevent and cure disease for which they are directly responsible.

I trust this paper will not be misinterpreted. I can not believe that it is the duty of the churches to preach social service altogether, but I do believe that our churches should give more time and more money to medical social service in their own community and State. And when this day arrives, I am sure that more men will be in attendance upon our churches and they will be supported financially as they deserve to be. If Christ was upon earth today, I doubt very much if He would remain passive with our large death rate from preventable diseases; and we as His representatives on earth, have a duty to perform which thus far has been sadly neglected. Here lies open before us a wide field for the practical application of the principles enunciated by Christ.

Necrology.

ALBERT MARK JONES.

I have been told that this young member of the Maine Medical Association was one of the most interesting and valuable internes ever connected with the Eastern Maine Hospital. Everybody on the staff liked and admired him, and his early death was much lamented by the physicians of Penobscot county, with whom he was most intimate. He was born January 5, 1872 in Brooks, Maine, and was a son of John Dow Jones and Rebecca Gray, his wife. After finishing the ordinary courses in education offered by his native town, he attended the Maine Central Classical Institute at Pittsfield, where he was graduated in 1896. He then entered and passed with honor through Bates College, graduating in the Class of 1900. He studied medicine at the Medical School of Maine, and obtained there his medical degree in 1904. Immediately afterward, he served for a year as an interne in the Eastern Maine Hospital, where he was regarded as a splendid fellow in every way; honest, faithful and intelligent.

At the end of his hospital service, he settled in Milo and married Miss Effie Gower Whitten of Lee, Maine. He soon obtained a promising practice, and also took great interest in the Boy Scout movement by which he hoped to build up a good knowledge of outdoor life and military education amongst the youth of the surrounding country. In the midst of his busy medical and surgical cases, he worked too hard, was seized with pneumonia and his career was cut short forever within a week. He died on Thursday, March 1, 1911. His widow and a child survive this able young man, one whom it is hard to lose from medicine, for such men go to fill up the ranks of our Association when thinned by the gradual decay in faculties, and death, of elder men.

J. A. S.

SMALL POX.

Hardly ten per cent of children born in England in the past five years have been vaccinated against small pox. The world will soon have an opportunity in England to see if the anti-vaccinationists are right in their belief that vaccination is not needed as a preventive against small pox.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

Pernicious Anaemia.

This disease, so difficult to deal with effectually, is now being treated with a considerable degree of success with salvarsan administered precisely as in syphilitic involvement of the body corporate. Although used both intravenously and intramuscularly the best results seem to follow intra-muscular injection. This may depend upon the slow and continuous absorption of the remedy through the muscles, in comparison with its rapid absorption when given into the veins. The benefit is supposed to be due to the arsenic contained in the salvarsan.

Dr. Bramwell's valuable paper on pernicious anæmia in the May 24th number of the British Medical Journal is well worth reading by every medical practitioner, for the enormous experience obtained after forty years utilization of hospital material to say nothing of a very extensive, private practice, makes a strong foundation upon which to base his valuable opinions in this disease.

Tetanus and Its Successful Treatment with Magnesium Sulphate.

A very valuable instance in which Tetanus was demonstrably cured by intraspinal injections of magnesium sulphate has been lately reported in the British Medical. Lumbar puncture was first performed, and then without withdrawing the needle 3 cc. of a 25% sterilized solution of the magnesium was introduced. Three similar injections in the course of nine days were followed by a cure. We note with

regret that the title of the paper in question says that the case was "Treated" but does not say "Successfully treated" as was the actual state of affairs. The result of the failure to specify a good result, caused prolonged reading of the paper to make one sure whether the injections were of any use. When will medical writers make their titles plain?

Left Handed Malingerer.

Many men who are injured in the left hand, but who are actually right handed, often assert that they used their left hand habitually, and in claims for indemnity under insurance laws they assert that as their useful left hand has been injured they are entitled to as much damages as right handed men are when their useful hand is damaged.

A useful way to discover such simulation of left handedness is to try an old fashioned child's game of moving one hand in a circle AWAY from the body and the other TOWARD it. Now with great exertion these two circular movements can be kept up for a while, but soon, one hand gains the mastery over the other and the less used hand begins to follow in the same circular direction with the other. If this game is played with an actually left handed person, the right hand will gradually follow the direction determined by the left hand, but if the right is the dominating hand the left hand gradually begins to follow the motion of that one. The idea is: that the dominating hand moves automatically, from prolonged and habitual use, whilst the other hand needs a steady impulse of the will to move in the opposite direction. When that impulse weakens, the less used hand lags behind, and soon follows the one habitually employed in labor.

Caesarean Section.

Several instances of Cæsarean section have been reported of late in England in which other causes than usual led to the operation. One case was due to cicatricial contractions and misplacements from a long previous operation for Ventro-Fixation of the uterus. A second was done for hemorrhage in a case of placenta prævia. A third was done for numerous intra-mural fibroids of the uterus. In all three of these instances, the result for mother and child was perfect.

A Medical Item from Spain.

A patient not long ago entered an institution for tuberculosis, and a physical examination revealed upon one of his arms these words tattooed, "Hurrah for Anarchy!" The surgeon-in-chief insisted on removing this bit of seditious skin, and later on, mentioned it at a

medical meeting. One physician alone, protested against the uncalled for operation, and said that in his opinion the operator deserved the jail, rather than congratulations. Others took the matter up, complained judicially against the calumniator, and the court punished the fault-finder with a year's imprisonment and four months' banishment from Barcelona where he had before practiced. Finally, the patients of the condemned man petitioned for a remission of the sentence, which they thought altogether too severe and disproportional to a remark uttered without forethought in the heat of argument and discussion.

The case is still in abeyance.

Mileage Under British Medical Laws.

Some districts of England are so much cut up with hedges, ditches, grass paths, banks of canals, and zig-zag bridges, that it is often impossible to determine the precise three-miles limit for a call from the attending insurance physician. If a crow can fly three miles straight away, a physician cannot, yet, and now he is asking proper rating for outlying patients who may live straight away three miles from his office, but who really are six miles away, and often along paths and tracks so impassible to vehicles of any sort that the physician is compelled to walk most of the distance. Physicians in such districts are now asking for more pay for attendance than those city or country physicians whose patients are accessible three miles away direct and attainable by suitable vehicles.

Color Blindness Agitation in Germany.

Owing to recent railroad accidents in Germany, due solely as thought to color blindness amongst the employees, public anxiety became so insistent that a meeting of the chiefs of all the Government Railroads was ordered with the result that a rigid re-examination will at once begin all over the nation. Recent study of this important defect has brought out new tests which are regarded as much superior to those so long in vogue.

Poisoning from Aspirin.

Several instances of poisoning from this useful anti-rheumatic remedy have been reported of late. The alarming symptoms are supposed to be due to the administration of the drug directly after drinking milk or any alkaline substances. The theory of the production of toxic symptoms following such administration is that the alkalies decompose the aspirin and develop large amounts of salicylic acid which in turn irritates the system and produces the untoward results.

The moral of the recent instances of poisonous symptoms is, that aspirin should be taken on an empty stomach, and unaccompanied with anything except water. Aspirin has proved so valuable in various rheumatic affections that it would be a loss to medical treatment if proper methods of its exhibition were not carefully followed out, in order that neither physicians nor patients need feel doubtful in using it.

Maine Medical Association.

The July meeting of the Maine Medical Association showed a registered attendance of 219 against that of 256 of the previous year.

This year marked an innovation of some few changes which will prove advantageous to the association when fully established.

The papers of this session proved most interesting and instructive as the attendance at the meetings amply proved. The House of Delegates continued the progressive policies of the past sessions and devoted some time to the consideration of medical legislation, hoping that two years hence we would be in a position to make some more satisfactory laws than are now in the Statute Books.

Another matter was the problem of amalgamation of the Maine Medical Journal with the Vermont Medical Journal, together with the New Hampshire Medical Society, in an effort to establish a North-eastern Medical Journal which would be the official organ of the three State Societies, to be published bi-monthly. This is in the hands of a committee to confer with similar committees from the adjacent States and report to the House of Delegates at the next annual meeting.

Another marked change was the introduction of the ladies at the annual banquet and we think that all in attendance will bear us out in the statement that the ladies added very materially to this most pleasant occasion and judging from remarks both written and oral, we sincerely hope that this will be an established custom in years to come. The entertainment committee, through the untiring efforts of Dr. Everett and his associates, succeeded in keeping the ladies so busy during their two days in our city that they even complained of their inability to do the necessary shopping. They were given an organ recital, an afternoon at the theatre, a morning automobile ride, an afternoon boat ride, and attended the annual banquet the first day. With the exception of the banquet, for which merely a nominal charge was made, the ladies were the guests of the Cumberland County Medical Society.

We are sorry for those who did not attend and can only recommend that they plan their vacation so as to reach Portland in time for next year's meeting. The total enrollment of physicians and their wives at this year's session would come close to 300 and we shall make

every effort at the next meeting to bring it nearer to 500.

The officers for the coming year will be found on the inside of the front cover page of the Maine Medical Journal.

America Medical Association.

The Minneapolis session of the A. M. A. proved to be interesting to all those in attendance and of great value to the members who attended the meetings of the various sections.

Minneapolis is an ideal convention city although unable to supply the amount of clinical material which should be accessible at a convention of this kind. Next year, the annual session will be held in Atlantic City, which is very accessible to all eastern men and we again call the attention of the members to the advantages offered at these meetings and urge all progressive men to strain a point and make every effort to be present.

The officers for the ensuing year are:

President — John A. Witherspoon, Nashville.

President-Elect — Victor C. Vaughn, Ann Harbor, Mich.

First Vice-President — Walt P. Conway, Atlantic City, N. J.

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Fraternal Lodge Work.

We recognize a legitimate form of contract practice but we feel it necessary to discriminate against that form which is derogatory to the physician himself and the whole profession as well as to the patient and the public.

Affiliation with any fraternal order or beneficiary association which offers a doctor's services at a fractional part of the lowest price in any fee taken as adopted by a county, is evidence of a breach of honorable conduct and the Secretary of the State Association should notify each component County Society that such County Society ought to be the judge of the qualifications and legitimate standing of the members and that the State Association expects each County Association to prevent such cheapening of medical service as to bring the profession in disrespect. The County Association is asked to brand as inferior whatever constitutes cheapness.

The Councillor in each district should give a personal interview to any member of the Association of whom complaint shall be made by his County Society.

C. B. S.

Public Health Notes.

Rice; a valuable food deprived of its nutriment by polishing.

Those who care for rice as a food, and nothing can be more nutritious when it is pure and properly cooked, will give thanks to Dr. Horace Packard of Boston for a recent letter in the Boston Medical and Surgical Journal in which he calls attention to the debased food now imposed upon the public in the shape of the so-called polished rice. Dr. Packard shows how the process of polishing deprives rice of those essential parts of the granule which go to form bone, teeth, nerves and brain matter, and substitutes or leaves in its place nothing but mere rice starch. Instead of enjoying actual pure rice, people eat robbed rice, covered with glucose and talc powder.

The suggestion made, by the writer of the letter, is that those who want nutritious rice must insist on having natural yellow-brown rice. If this is boiled properly, and then steamed dry and served in its natural flaky form, it is an excellent food-vegetable as we may say, and makes a most desired change from our daily potato diet. Speaking of potatoes, who knows as every one should, that the peeling of potatoes before they are boiled deprives them, also, of the nutrition which lies just beneath the discarded skin. Potatoes should be boiled with the skin on them.

Aphorisms in Modern Urinary Practice.

Never pass a catheter the first time that you see a patient, unless compelled.

Never catheterize during acute gonorrhœa. Never wash the anterior urethra during acute gonorrhœa.

Never dilate when there is much resistance in a stricture. Don't cocaine the canal without peremptory reasons.

Do not omit a rectal examination in urinary subjects. Explore with a metal sound, when patient complains of pain in the glands.

Always resort to cystoscopy in doubtful cases. Resort to cystoscopy in hæmaturic patients at a suitable period, which means, in vestical hæmaturia, between the bleeding periods and in renal hæmaturia during the actual bleeding.

In uncertain renal cases, try the X-Ray.

A tuberculous kidney is small.

Hæmaturia in the evening is calculous.

Do not use silver salts in urinary tuberculosis.

Tuberculous urine is never ammoniacal.

—Dr. Cathelin in "Le Monde Medical.

Medical Examiners.

The Legislature of 1909 passed a law providing for the appointment of medical examiners to serve for four years. The law says that one or more of these examiners may be appointed in a county and the terms of the following will expire on July 10th, next:

W. L. Haskell, M. D., of Lewiston, for Androscoggin County; Sherman W. Boone, M. D., of Presque Isle and Frank H. Jackson, M. D., of Houlton, for Aroostook County; Thomas F. Conneen, M. D., of Portland and Frank N. Whittier, M. D., of Brunswick, for Cumberland County; George L. Pratt, M. D., of Farmington, for Franklin County; E. J. Morrison, M. D., of Eden, for Hancock County; W. H. Harris, M. D., of Augusta, for Kennebec County; George L. Crockett, M. D., of Thomaston, for Knox County; George A. Gregory, M. D., of Boothbay Harbor, for Lincoln County; H. L. Bartlett, M. D., of Norway, for Oxford County; Everett T. Neally, M. D., of Bangor, for Penobscot County; W. S. Stinchfield, M. D., of Skowhegan, for Somerset County; Orris S. Vickery, M. D., of Belfast, for Waldo County; Stephen E. Webber, M. D., of Calais, for Washington County, and D. W. Wentworth, M. D., of Sanford, for York County.

The terms of the following as county examiners of insane convicts will expire July 10th, next:

Androscoggin, B. G. W. Cushman, M. D., Auburn; Cumberland, F. H. Gerrish, M. D., Portland; Franklin, A. G. Howard, M. D., Farmington; Kennebec, O. C. G. Davies, M. D., Augusta; Knox, Albert Woodside, M. D., Rockland; Lincoln, W. H. Parsons, M. D., Damariscotta; Oxford, H. L. Bartlett, M. D., Norway; Penobscot, Eugene B. Sanger, M. D., Bangor; Piscataquis, E. A. Thompson, M. D., Dover; Somerset, L. A. Dascomb, M. D., Skowhegan; Washington, Fred A. Chandler, M. D., Addison; York, James C. McCorrison, M. D., North Berwick.

Also the terms of Drs. W. S. Thompson and W. H. Harris of Augusta, as members of the Board of Registration in medicine will expire during the month of July.

A gastronomic artist named Morton is astonishing the medical profession of France and Germany by his ability to drink 6 liters of water at one gulp, as it were, and then slowly to eject it through his lips like a living fountain. He can likewise swallow live frogs and gold fish into the water thus intaken and, at pleasure, return them alive to the outer world. Oddly enough he is said to be able to eject the frogs first or last, no matter even if they were taken into the stomach before the gold fish or afterward; an odd process of natural selection. This man's Father and Grandfather had the same enormous capacity for imbibition of fluids, but only in the present generation has it been utilized for gain and fame.

Book Reviews.

Volume 1 of the twenty-third series of the International Clinics contains in its chapters many interesting original articles. Francis Reder, M. D., of St. Louis, contributes a paper, describing a new sign of diagnostic value in obscure cases of chronic appendicitis.

The contribution of Albert Abrams, M. D., on the "Treatment of Aneurism," is especially valuable and interesting from the standpoint of physical diagnosis.

"The Care of the Woman during her thirty-nine weeks of Gestation," by Greer Baughman, M. D., contains some good points, but on the whole it is a summary or review of well known facts, made use of by all obstetricians. His explanation of Leopold's plan for pelvic measurements, and the citing of his personal statistics is interesting.

The complete chapter on "The Progress of Medicine during 1912," is particularly valuable and instructive. J. B. Lippincott Co., Publishers. The price of the book is \$2.00.

A. P. L. J.

Transactions of the American Academy of Ophthalmology and Otolaryngology for 1912.

This book of something over 400 pages contains the latest thought in the topics discussed before this academy. Particular attention should be paid by every oculist to the Address on Sympathetic Ophthalmia by Professor Elschnig of Prague. For in it the latest theory of this dread disease is most carefully detailed. Fortunately for the human race the disease in question is becoming rarer than of old, but those specialists who still operate, for instance, upon a cataractous eye before the other is at all affected, will find food for thought in the instances of sympathetic ophthalmia still following such operations even with the most perfect antiseptic precaution and delicate skill with the various instruments. A large number of other valuable papers can be found within the contents of these transactions, and the discussions, especially, are of great value. I might refer particularly to the discussions on instruction in ophthalmology and the lack of support to special literature by specialists of today. It is amazing to think what small education some obtain, and equally astonishing that so small a percentage ever purchase any recent special literature or subscribe to a special magazine. Those who are interested in Otolaryngoscopy will find much of interest in the special papers on various modifications of the mastoid operation, on new methods in laryn-

gосcopy and on the removal of foreign bodies from the œsophagus. Mention may also be made of a curiously new disease entitled othygroma nephriticum; with an illustration.

It is a pity that the book should weigh so much (nearly three pounds) but medical publishers seem to have no idea of ever using light weight paper for medical books.

J. A. S.

The Career of Dr. Weaver.

By Mrs. Henry Backus. L. C. Page & Co., Publishers. Boston. Price, \$1.25.

To tell the truth, we peeped into this novel two or three times with doubt and hesitation, and were rather inclined after a rapid reading to lay it aside as hardly worth the while of a perfect reading. Some one has, however, suggested a careful reading and this we have at last accomplished. Here then we have many glimpses into the wonderful career of Dr. Weaver, expert laryngologist, who five years before the story opens was borrowing money to set up a private hospital for treatment of his own patients. Now, he makes nothing of seeing fifty cases a day, operating on a dozen of them with marvellous and successful skill, then dining out and ending the day long after midnight at balls, parties and dances amongst the ultra fashionable set of the New Rich in New York. In a word, Dr. Weaver is famous. The author however, does not fail to show that fame has been built up on unethical methods, such as advertising his private hospital; wide spread pamphleteering to the number of sixty thousand copies of reports of operations, the diagnosis and determination for which were accomplished by Dr. Weaver's own brother, Dr. Jim, of whom he makes no mention; political scheming; splitting of fees; and interminable newspaper notoriety carried on in shady styles.

At the end, comes awakening and regret, and a better man. Intermingling with the stirring narrative of a busy practice in hospital and office, are the love affairs of Dr. Weaver and Dr. Jim, both of which end delightfully.

We can, now, heartily recommend this entertaining medical novel to our medical brethren for an evening of leisure, as an excellent description of the latest dash in medical advancement at any cost to any rash competitor.

J. A. S.

Training of Midwives in Relation to the Prevention of Infant Mortality.

BY CLARA D. NOYES, SUPERINTENDENT OF TRAINING SCHOOL,
BELLEVUE HOSPITAL.

This is a paper read before the International Congress of Hygiene and Demography in Washington, and is based upon a careful study of the midwife, both here and abroad, particularly in England, the investigation being under the auspices of the Russell Sage Foundation.

In America the midwife is found to be pushed into the background by the medical profession and a member of a class conspicuously ignorant and untaught and totally unfit to discharge the duties it is called upon to perform. In spite of all this, Dr. J. Whitridge Williams says, "It appears that the majority of teachers in this country consider that general practitioners lose as many and possibly more women from puerperal sepsis than do midwives." In America, as in the Old World, they are attending approximately 50% of all births; in New York City alone, 50,000 births annually. In Boston, where the law of the State forbids them to practice, they are recognized on a birth certificate, and their signatures accepted.

In England there are excellent schools, with courses varying in length from six months to two years. In Denmark, where the same is true, midwives practically control the practice of midwifery, and the infant and maternal death rates are both remarkably low. Control and supervision serve to maintain a high standard of work, and in England the death rate among infants has dropped from 151 per 1,000 in 1901 to 106 per 1,000 in 1910, the decrease in maternal deaths from puerperal sepsis and accidents of child-birth being almost as great. It has been proved that trained midwives, instead of invading the province of the physician, have actually resulted in greater demands upon their services. The more highly trained and educated the midwife, the less willing will she be to assume the responsibilities which are not hers, the more quickly will she recognize them, and the greater discrimination will she show in the type of physician she calls to her assistance.

The School for Midwives at Bellevue Hospital is the only one of the kind now in existence in this country, and the author feels that it is doing a vast amount of good in the training of intelligent women to care for those who in any event would not employ a doctor or go to a hospital. There the pupil midwives each see from sixty to one hundred cases, and personally deliver eight to twelve; particular emphasis is placed upon prenatal care of the mother and her surroundings, the nursing care of the mother and infant, and the importance of breast feeding. The pupils are also required to do all the housework, thus being trained in cleanliness, cooking, sanitation and hygiene. The need of more such schools is urged, and especially the need of adequate and careful regulation and supervision of those in practice.

R. B. M.

Review of Current Literature.

A Study of the Wasserman Reaction in connection with Hereditary Syphilis.

BY L. R. DEBUYS, M. D., NEW ORLEANS, LOUISIANA.

American Journal of Diseases of Children. January, 1913.

From a study of 244 Wasserman reactions, the author makes the following:

1. The Wasserman reaction is a reliable means of diagnosis in hereditary syphilis.
2. In many instances, because of the difficulty to obtain the blood from a very small baby, an examination of the mother's blood will suffice for corroborative diagnosis.
3. Some of the symptoms found in syphilis may be found in non-syphilitic cases, and a negative Wasserman is of decided help in the elimination of syphilis in the diagnosis of these cases.
4. It is interesting to note that the blood of the father and mother react in the same way.
5. The law of Colle has again been disproved, because if a syphilitic child is born, the mother, though apparently healthy, is in reality not so, but has had syphilis in a modified form, proof of which can be shown by the Wasserman reaction.

R. B. M.

Sterility in the Female.

Surgery, Gynecology and Obstetrics. December, 1912.

DR. CHAS. C. NORRIS' CONCLUSIONS ARE:

1. One in seven or eight marriages is sterile. 50% to 75% of these are due to sterility of the woman.
2. Sterility may be local and general. The success depends upon the correct diagnosis of the etiological factor present in each case.
3. Excluding gonorrhea, the three most frequent causes of sterility are uterine hypoplasia, cervical constriction, and a mild grade of cervicitis.
4. The routine practice of dilating and curetting every patient's cervix, without ascertaining if the woman or her partner is at fault cannot be too strongly condemned.
5. When hypoplasia, a cervical constriction or antiflexion is present, a stem pessary offers great relief and advantages. It straightens out flexions and develops the infantile uterus and cures 75% to 80% of expulsive dysmennorrhœic cases.
6. No ill effects follow this line of treatment by the pessary.

Vaccines in the Treatment of Puerperal Sepsis.

Rowlett, *British Medical Journal*. August, 1912.

The application of vaccines to obstetric practice was at a date somewhat later than in general surgery, it not being heralded a great therapeutic agent until Western of the London Hospital published the results of his treatment of 100 cases of puerperal sepsis.

Of the 56 cases treated by vaccines 18 or 32% died. Of the 44 cases untreated, 24 died or 55%.

Taking only the cases in each series in which bacteriological evidence of a blood infection was shown, he found of 7 inoculated cases 14 or 52%, of 16 untreated, 14 or 87.5% died. Western employed autogenous vaccines in every case where possible, about two-thirds. In several he found that cases which showed no improvement with stock vaccines, responded at once to an injection of autogenous vaccine.

Dr. Rowlette now considers cases of his own experience which occurred in the interne maternity of the Rotunda Hospital, Dublin, and takes up 54 cases. Bacteriological diagnosis was made in 39 and vaccines used more or less on chance in the remainder.

Streptococcic and staphylococcic infections were the only ones found in the entire series.

Streptococcal infections were given an initial dose of 5 millions, while in staphylococcal infections, a larger dose was used.

31 cases of streptococcal infection were treated. The number of inoculations varied from one to nine. Death occurred in 3 cases but one was septic peritonitis and one was complicated by a gangrenous appendix.

No harm ever occurred from the administering of the streptococcal vaccines and this is in direct contradiction to the reports and opinions of some observers. In a fair number of cases it was possible to say that the effect of inoculation was definitely good. Some of the cases were really dramatic in the effect of the vaccine inoculations. In the majority of cases, distinct amelioration of symptoms followed each inoculation. In other cases, he was justified in assuming that the inoculation tended to prevent the development of the infection to a dangerous degree.

The staphylococcal cases were eight in number. The number of inoculations varied from one to six. One patient died of pyæmia, the result of thrombosis of the ovarian veins.

Doubtless other treatment had a very considerable part in obtaining results. As long as retained membranes and infected decidua remain in the uterus as a nidus for organisms, one cannot hope to

secure immunity through inoculation. Douching as well as supportive measures were employed.

He makes the following conclusions:

1. Vaccines given in small doses do more harm in puerperal sepsis.
2. In a great majority of cases they do good.
3. In many cases they produce immediate and remarkable improvement.
4. Autogenous are more trustworthy than stock vaccines, and sometimes succeed where the latter fail.
5. Anti-streptococcus serum given simultaneously increases the effect of the streptococcal vaccine.
6. To get the best results accurate bacteriological diagnosis is necessary.

A. P. L., JR.

The Surgical Treatment in Puerperal Sepsis.

By WM. E. DARRALL, M. D., ATLANTIC CITY, N. J.

Surgery, Gynecology and Obstetrics. September, 1912.

It is difficult to lay down positive rules for guidance for operative measures. Good judgment and wide experience are required to make the decision when to operate and when not to.

Exploration should be done under strict asepsis. The gloved finger should be used in all cases possible, reserving the curette for those cases in which the retained products cannot be removed with the finger or the douche. The curette must be used with the greatest skill and judgment. If the lochia is scanty or purulent and evidence of retained products is not present the curette is contraindicated. If the uterine cavity presents a smooth surface, as in streptococcic infection, the curette is prohibited.

After infective organisms have penetrated the body of the uterus or spread to the lymphatics, then the curette is useless and even harmful. A distinction is made, however, between infection occurring after abortion in the early months of pregnancy and infection after labor at or near term. In the former instance, if done early the curettement gives most favorable results.

If pus presents in the pelvis it should be evacuated through Douglass's pouch or if it is in the broad ligament incision should be made in the abdominal wall to Poupart's ligament.

Puerperal peritonitis has been treated surgically with some success, but the flat-bellied type due to streptococcic infection is hopeless. In general puerperal peritonitis operation should be done early or not at all.

Removal of the uterus should be done if there is extensive injury to the uterus, such as rupture, perforation or infective tumor or abscess of the uterine wall.

The Journal of Epththalmology and Oto-Laryngology. January.

The Ozena Problem.

RALPH H. PARKER, M. D., DES MOINES, IOWA.

Comparing ozena, a term used to signify inflammation of the nasal mucuous membrane, with the general term "peritonitis" as formerly used, the writer urges a more rational classification made in accordance with the pathology found. Careful analysis of the literature as to the etiology of ozena brings out the fact that ozena is not always a disease in itself, but may be a symptom of an inflammatory process anywhere in the nasal cavity or communicating sinuses.

Several conditions classified as ozena but traceable to a definite pathology are:

1st. Syphilitic lesions within the nasal cavity.

2nd. Operations upon the lower turbinate. For this reason special emphasis is laid upon more conservatism in the surgical treatment of hypertrophied turbinates.

3rd. Operations for adenoids for their mere presence and a free nasal fluid discharge.

4th. Nasal gonorrhea in the infant.

5th. Inflammation of the adjacent sinuses.

In the search for a definite micro-organism no one has constantly been found and as yet the disease has not been reproduced by inoculations. The history of these cases suggests a syphilitic taint or a tubercular tendency, and the author feels there is a rich field for investigations along these lines.

E. E. H., JR.

Potential Cancer of the Breast.

BY MILES F. PORTER, M. D., FORT WAYNE, INDIANA.

American Journal of Obstetrics. December, 1912.

By potential cancer, Dr. Porter means warts, moles, eczematous patches, fissures, etc., which may possibly develop in time into malignant growths. It has been proved by experiment that epithelial cells can be preserved in ascitic fluid, and when transplanted after being preserved as long as three months, will not only grow but will penetrate granulation after the manner of carcinoma. The prevailing view as to the origin of cancers is that they grow from just such "rests," which have been detached in process of development or as a result of inflammatory changes or abnormal involution. That irritation of glandular epithelium by micro-organisms will excite it to multiply is well known, and it is also a matter of common observation

that carcinoma is much more prone to arise in organs which are the seat of chronic inflammatory changes than in those thoroughly healthy. So far as our present knowledge goes, there is no such thing as a cancer cell that can be recognized microscopically. A group of epithelial cells that are normal today may tomorrow take on cancerous activity, especially if they have been detached by inflammatory or other pathologic processes. He cites several cases to show that benign tumors and such pathologic processes as occur in the breast from chronic inflammation, abnormal involution, and trauma, are potentially cancerous; that actual cancer as demonstrated by microscopic examination may be present without palpable tumor formation; and that the only way to differentiate between potential cancer and actual cancer is by microscopic examination. His conclusions are that all potential cancers require excision, and that all demonstrable cancers require radical removal.

County News.

CUMBERLAND.

The fifth regular meeting of the year was held at the Columbia Hotel on May 1st, 1913, with twenty-six members present. The President appointed Drs. S. E. Fisher, M. C. Webber and A. P. Leighton, Jr., to serve with the secretary as the Committee on the Annual Outing, to be held in June.

Dr. A. P. Leighton, Jr. reported a case of pernicious vomiting of pregnancy which was relieved by the administration of thyroid extract after other remedies had failed.

The paper of the evening was by Dr. Benjamin B. Foster, his subject being "Primary Lues and the Dark Field." He sketched a brief resume of the long-continued search for and final discovery of the organism causing syphilis, and described the difference between the *treponema pallidum* and other organisms which might be confused with it. Emphasis was laid upon the importance of an early diagnosis of the disease and the institution of treatment before secondary symptoms appear. Modern diagnostic laboratory methods render it easy for a trained observer to do this, and will often result in a much more satisfactory response to treatment.

Following the paper, the essayist exhibited slides of the spirillum macrodentium and spirillum microdentium on the dark field, and pointed out their resemblance to and points of difference from the *treponema pallidum*.

The paper was discussed by Drs. Alfred Mitchell, Jr. and Williamson, and all the members present took great interest in the microscopical preparations which were shown.

R. B. MOORE, *Secretary*.

PORTLAND MEDICAL CLUB.

The annual outing and field day of the Portland Medical Club was held at Mitchell's, Spurwink, on June 12th. Forty members were present. An exciting ball game was played by two picked teams, the exact score being still in doubt. Following this event, those present were served with one of Mitchell's famous shore dinners, to which all did full justice.

KENNEBEC.

June 14th, 1913.

The regular June meeting of the Kennebec County Medical Society was held at the Hotel Elmwood, Waterville, on Friday evening, June 13th at 7.30 P. M.

Supper was served in the hotel dining-room, after which Pres. Beach introduced Dr. John McCrae of McGill University, Montreal, who read upon "Scarlet Fever. Its complications and Treatment."

Dr. McCrae who is connected with the Alexandria Hospital for Infectious Diseases in Montreal, handled his subject in a most fascinating and enlightening manner. His experience in scarlet fever is based upon 2,200 cases, which have come under his observation. His manner of presentation and his exceptionally well arranged summary of his experience enhanced the value of his address.

A rising vote of thanks was extended to Dr. McCrae for his instructive and brilliant presentation.

Twenty-five members were present.

H. W. MILLER, *Secretary*.

OXFORD.

The 87th annual meeting of Oxford County Medical Society was held at Rumford on the afternoon and evening of June 17th.

The afternoon was spent in watching an interesting ball game at which we were guests of the athletic association, and in looking over the city. A business meeting was held at 6.30 in the office of Dr. Nile and six applications for membership were accepted by the society.

At eight o'clock, a very satisfactory banquet was served at Hotel Rumford to about fifty members and friends of the society and immediately following the banquet the usual literary and musical program was held in the Business Men's Club.

It has for many years been the practice of the society to invite the ladies to attend the June meeting. This custom has invariably proven successful, and since under this arrangement it became necessary to secure a speaker whose subject would be interesting to those outside the profession, this year several literary societies and other invited guests were added. We were fortunate in securing as speaker, Dr. H. W. Miller of the Augusta State Hospital, whose paper on "Eugenics" was both interesting and instructive, and our only regret was that all the representative citizens of the county were not present to hear it.

In this way, we believe we can strengthen the position of our society in the county and what is even more to be desired, we hope the county will be better able to understand their medical and sanitary needs.

D. M. STEWART, *Secretary*.

YORK.

The 73rd quarterly session of the York County Medical Society was held at the Stone Haven, Cape Porpoise, Friday, June 27. This was the annual Summer Outing of the Society, and the ladies were present. A shore dinner was served at 1 o'clock. A business meeting preceded the dinner.

ARTHUR L. JONES, *Secretary*.

Personal News and Notes.

Dr. D. L. Harden, having been appointed surgeon to the Canadian Pacific R. R., in the place of Dr. Hayes, who was killed in a railroad accident, last spring, has removed his office from Brownville to Brownville Junction.

Dr. G. B. Weatherbee of Boston, Mass., is at present acting as assistant to Dr. D. L. Harden.

Dr. E. C. Higgins has opened an office at Phillips.

Dr. H. W. Stanwood is now practicing with his father in Rumford.

Dr. H. H. Leute has opened an office at Brownville.

Dr. B. F. Bradbury of Norway, Dr. C. F. Kendall of Biddeford, Dr. H. R. Farris of Oxford, and Dr. D. M. Stewart of So. Paris, who are officers of the Medical Corps of the National Guard of the State, accompanied the veterans of Maine on their recent trip to the Gettysburg celebration.

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